EXHIBIT E

EXHIBIT E

Medha Bharadwaj, FLMI, ACS
CIGNA Group Insurance
D212
12225 Greenville Avenue
Suite 1000
Dallas, TX 75243-9337

Phone: 800-352-0611 ext. 1249
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CIGNA Group Insurance
Life · Accident · Disability

TODD NASH
2730 FERNGLEN RD
CARLSBAD, CA 92008

July 10, 2006

Name:	TODD NASH
Plan/Policy Number:	SLK0030024
Plan/Policy Holder:	ADMINISTAFF OF TEXAS, INC
Underwriting Company:	Life Insurance Company of North America

DEAR TODD NASH,

We have carefully reviewed your claim for Long Term Disability (LTD) benefits, in accordance with the Employee Retirement Income Security Act (ERISA) of 1974, and must affirm our previous denial of your claim. Please refer to our December 13, 2005 letter for specific policy definitions and previously reviewed information.

In order to qualify for continued Long Term Disability Benefits, you must continue to meet the Definition of Disability as follows:

Definition of Disability

"The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is either:
1. unable to perform all the material duties of his or her Regular Occupation or a Qualified Alternative; or
2. unable to earn 80% or more of his or her Indexed Covered Earnings.

After Disability has lasted 30 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is either:
1. unable to perform all the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; or
2. unable to earn 80% or more of his or her Indexed Covered Earnings."

Disability Benefits

"The Insurance Company will pay Disability Benefits if an Employee becomes Disabled while covered under this Policy. The Employee must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. He or she must provide the Insurance Company, at his or her own expense, satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits.

The Insurance Company will require continued proof of the Employee's Disability for benefits to continue."

Termination of Disability Benefits

"Benefits will end on the earliest of the following dates:

"CIGNA" and "CIGNA Group Insurance" are registered service marks and refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Life Insurance Company of North America, CIGNA Life Insurance Company of New York, and Connecticut General Life Insurance Company.

1. the date the Employee earns 80% or more of his or her Indexed Covered Earnings;
2. the date the Insurance Company determines he or she is not Disabled;
3. the end of the Maximum Benefit Period;
4. the date the Employee dies;
5. the date the Employee refuses, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan;
6. the date the Employee refuses, without Good Cause, to fully cooperate in a Transitional Work Arrangement;
7. the date the Employee is no longer receiving Appropriate Care;
8. the date the Employee fails to cooperate with the Insurance Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.

Benefits may be resumed if the Employee begins to cooperate fully in the Rehabilitation Plan or a Transitional Work Arrangement within 30 days of the date benefits terminated."

Overview of Eligibility of Benefits

We based our decision on your claim for benefits upon Policy language and all documents contained in your claim file, viewed as a whole.

The following information was reviewed as part of your appeal:

- Exhibits 1 through 37

I am aware that you have been off work since September 29, 2003 due to osteoarthritis of the hip. As stated to you in our letter of June 20, 2006, we conducted a medical review. As part of his review, our medical director reviewed all the medical information contained in your claim file.

After review of the entirety of the medical information in your file, our medical director noted that most of the medical information provided were several years old and prior to when your Disability benefits ended. Our medical director noted that you saw various physicians From December 2005 to April 2006 and also underwent a FCE in March 2006. However this information is several weeks to several months after your Disability benefits ended and does not provide evidence of continuous Disability as of November 30, 2005, when your benefits ended. Our medical director also stated that although surgery was recommended 6 weeks after your benefits ended, the medical records in file do not support severity of any condition as of November 30, 2005 that would support limitations and/or restrictions precluding you from performing your occupation.

Summary

Mr. Nash, the policy provides that Life Insurance Company of North America would pay benefits only if you met the policy's requirements. Disability is determined by medically supported limitations and restrictions which would preclude you from performing the duties of your light occupation as a Vice President. The presence of a condition, diagnosis or treatment does not equate disability under the plan. While the documentation on file described your conditions, it does not provide clinical findings that would support the severity of your condition and functional deficits that would preclude you from performing your occupation as of November 30, 2005, when your Long Term Disability benefits ended. As such, we are reaffirming our previous denial decision of December 13, 2005 within the meaning and terms of your group Long Term Disability plan.

You may request a review of this decision by writing to the Life Insurance Company of North America Representative signing this letter at the address noted on the letterhead. The written request for review must be sent within 180 days of the receipt of this letter. In addition to any written comments, your request for review must include new documentation you wish us to consider. Under normal circumstances, you will be notified of a decision on your appeal within 45 days of the date your request for review is received. If there are special circumstances requiring delay, you will be notified of the reason for delay within 30 days of receipt of your request, and every 30 days thereafter. A final decision will be made no later than 90 days.

July 10, 2006
Page 3

Please note that you have a right to bring legal action regarding your claim under the ERISA section 502(a). You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local United States Department of Labor Office or your State Insurance Regulatory Agency.

Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein.

Please review your insurance booklet, certificate or coverage information available from your employer to determine if you are eligible for additional benefits.

Section 2695.7 (b) (3) of the Regulations of the California Insurance Department requires that our company advise you that if you wish to take this matter up with the California Department of Insurance, you may contact the California Insurance Department. Their address is California Department of Insurance, Consumer services Division, 11th Floor, 300 S. Spring Street, Los Angeles, CA 90013, (213) 897-5961, or (800) 927-HELP (4357).

Please contact our office at 800-352-0611 ext. 1249 should you have any further questions.

Sincerely,

Medha Bharadwaj

Medha Bharadwaj, FLMI, ACS
Appeal Claim Manager

EXHIBIT
F

EXHIBIT F

EXHIBIT F

THOMAS M. MONSON*
MARY J. PESHEL*
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ROBERTA D. REPASY*
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January 4, 2007

REPLY TO FILE:

59812-01-14

Medha Bharadwaj
Life Insurance Company of North America
CIGNA Group Insurance D212
1225 Greenville Ave., Ste 1000
Dallas, TX 75243-9337

RE:		
RE:	Claimant:	Todd Nash
	LINA Group Policy #:	SLK-030024 (effective 1/1/2000)
	DOD	Sept. 26, 2003
	Disabling Condition:	Severe / advanced post-traumatic osteoarthritis of left hip
	Occupation:	V.P of Business Development
	STD Period:	14 day elimination period; six months STD benefits
	Own-occupation LTD	3/29/04 - 3/26/06 (30 months from 9/26/03)
	LTD termination letter	12/13-14/05 (p.2-6 state Dec. 14); faxed 12/13/06, hard copy received 12/21/05, denying benefits payments following 11/30/05
	1st appeal	6/1/06
	Denial of appeal	**7/10/06** (postmarked 7/13/06, received 7/16/06)
	180 days from receipt	1/12/07

Dear Ms. Bharadwaj:

Mr. Todd Nash has asked this office, which now represents him, to assist in presenting his appeal of the July 10, 2006 (second) denial letter (postmarked July 13), which he received July 16, 2006.

Page numbering:

We have made reference to many of the records in the claim file. For your convenience so that you can readily locate them, we numbered the pages of the claim record copies that you provided Todd. The page numbers of the claims file records (which obviously include his prior appeal) are numbered "**TN_2APP**" (immediately followed by the page number). (E.g., claim file to date are numbered TN_2APP0001 - TN_2APP1329); additional pages to TN_2APP1413.

Attached immediately following this letter are additional exhibits and thus are numbered without the reference to any existing claims file number. They are TN_2APP_Ex.0001-0010.

We have reviewed the materials in the claims file, including the initial **LTD termination bearing dates of December 13 and 14, 2005** (received via fax on that date, and mail copy on 12/21/2005) (TN_2APP0524 to 0529), and Todd's appeal of the reasons LINA stated in its "December 13/14, 2005" letter. That appeal was submitted 5/15/2006 (TN_2APP0129 to 0185 and 0191 to 518) and supplemented through addendum materials on 6/1/2006 (TN_2APP0186 to 0190, and 0519 to 521).

We have also reviewed the second adverse determination letter dated "July 10, 2006" referenced above. This appeal letter and referenced exhibits will address the reasons articulated in that July 10, 2006 letter.

This unfortunate man is unquestionably disabled. He has continuously been so since September 2003. He has MAJOR impairments, limitations and medical restrictions arising from his *advanced* hip disease.

As you know, Todd Nash currently 43 years of age, was Vice President of Business Development at Morpho Technologies, Irvine, CA, a client of Administaff of Texas, Inc. With 20 years experience, Todd was considered a key employee and his presence was required in the offices of the company at all times except travel to potential customers, including internationally. Vice President of Business Development is in the field of sales and marketing. It primarily required **sitting, to work all day**, five days a week —a sedentary occupational level by definition, and involved periodic travel within the United States and internationally. Like his occupational requirements in the office, the travel requirements involved **sitting** on the plane for hours during the travel itself, and **more sitting** in meetings with the prospective clients –also sedentary-level activities.

The file contains detailed information about the exertional, nonexertional/positional as well as sustained high-level mentation and other requirements of his highly cognitive profession both as described in the now-outdated Dictionary of Occupational Titles (D.O.T.), fourth edition, revised 1991, and the Department of Labor's replacement of the D.O.T., "O*NET". O*NET was endorsed by, among many other entities, the American Insurance Association (AIA), the Insurance Information Institute , the National Associations of Independent Insurers (NAII) and of Group Underwriters Association of American (TN_2APP1359-1360).

For a general time line of his disability from 9/26/2003 to date, see APPENDIX I to this letter.

Early history:

Briefly, Todd's hip symptoms, while not then disabling, began to noticeably appear in the early months of 1998[1] as increasing pain and stiffness in the left hip area, with difficulty tying his shoe laces. His hip flexion was then approximately 75°. We recap this history only briefly, as his disability did not begin in 1998 or, in fact, until 5 ½ years later, but it is important in understanding the beginning of his positional limitations and his attempts to accommodate them during the subsequent marked advancement of degeneration and destructive process that progressively occurred in the left hip since 1998 until he finally became disabled from it. We will discuss the clinical sequella and marked symptomatology of his end-stage left hip disease and its limitations and medical restrictions.

Progression of disease by 2003 and associated symptoms and disability 9/26/2003.

In **August 2003**, Todd was again seen due to increasing intolerance to exertional and nonexertional activities due to his ever-increasing hip pain from advanced osteoarthritis, and his desire to learn of any other measures that might assist in controlling his pain. Todd saw Robert Duff, M.D. His hip symptoms included constant pain deep inside the left hip, popping in the hip, severely limited range of motion, with difficulty even putting on his socks and inability to tie his shoes, severe pain with prolonged sitting or when he walked or stood for extended periods of time, and difficulty walking up/down stairs. (TN_2APP0079 - 0080). Other medical follow up notes of the same time period described "severe pain when sitting in a confined area such as a chair or an airplane seat for any length of time, ranging from as little as 45 minutes to 90 minutes. Sitting after 90 minutes increases his pain and increases the length of time that he takes to recover." (TN_2APP0077). Dr. Duff referred Todd to orthopedic surgeon and hip specialist, **Behrooz Tohidi, M.D.**, then of the San Diego Joint Replacement Medical Center, Encinitas CA.[2]

The horizontal radiological study (X-ray) of the left hip demonstrated **the "old left femoral neck fracture deformity with some remodeling**" arising from the distant motor vehicle accident, it also demonstrated increased "**osteophytosis and superior joint space narrowing**," or in

[1]The 3/2/2003 X-ray of the LEFT hip at the request of his physician Dr. Duff, showed mild degenerative change with some subchondral sclerosis /cyst formation in the acetabular region per additional overread by his physician **Dr. Leonard Ozerkis**, and osteophyte formation and slight joint space narrowing superiorly and laterally. (There was no *acute* fracture or dislocation nor localized destructive process). TN_2APP0039 and 0051. Dr. Ozerkis advised Todd to that he would need a total hip sometime in the future but that he should hold off and keep his native hip as long as he could.

[2]Currently, and since October 2005, with the Emanuel Medical Center, Swainsboro, Georgia, General Orthopaedic with emphasis on Joint Replacement and Arthroscopic Surgery

conclusion, **"MODERATE TO SEVERE LEFT-SIDED OSTEOARTHRITIS** SLIGHTLY PROGRESSED COMPARED WITH PRIOR STUDY [of 3/2/98]."[3]

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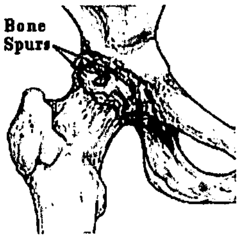
[3] "The term "**arthritis**" means inflammation of a joint, but is generally used to describe any condition



Joint
Space
Lost

Todd's radiologic AP standing views, taken 8/8/2003, read by Dr. Stephen Schmitter, radiologist, demonstrated:

> **Deformity** of the proximal **left** femur is again identified . . . . There is **severe osteoarthritis** with **near complete obliteration of the super lateral joint space** of the left hip on upright views.
>
> **IMPRESSION**: PRESUMED OLD POST-TRAUMATIC CHANGES OF THE LEFT PROXIMAL FEMUR WITH SEVERE DEGENERATIVE CHANGES AS DESCRIBED ABOVE.[4]

(TN_2APP0005). See also **Dr. Ajir's** associated medical notes. TN_2APP0055.

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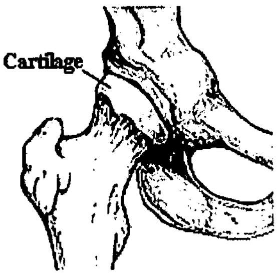
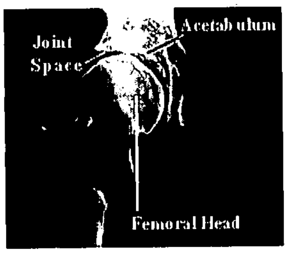
in which there is **damage to the cartilage**. Inflammation, if present, is in the synovium. The proportion of cartilage damage and synovial inflammation varies with the type and stage of arthritis. Usually the pain early on is due to inflammation.. In the later stages, when the cartilage is worn away, most of the pain comes from **the mechanical friction of raw bones rubbing on each other**." . . . **Bare bone on the head of the femur grinding against the bone of the pelvic socket causes mechanical pain**. Fragments of cartilage floating in the joint may cause inflammation in the joint lining, and this is a second source of pain. X-rays show the "joint space" to be narrowed and irregular in outline." Huddleston, Exhibit TN_2APP 1330-1422 hereto.

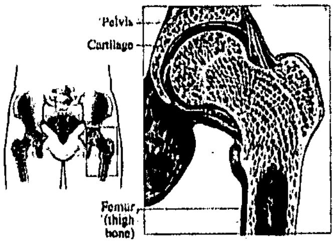
[4] In the normal hip, "an x-ray of the hip joint usually shows a "space" between the ball and the socket because the cartilage does not show up on x-rays. In the normal hip this "joint space" is approximately 1/4 inch wide and fairly even in outline." Huddleston, at Arthritis of the Hip Joint, Exhibit 1330-1442 hereto. http://www.hipsandknees.com/hip/hipdisease.htm (1 of 2) 11/24/2003 3:56:13 AM

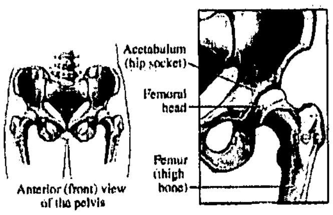




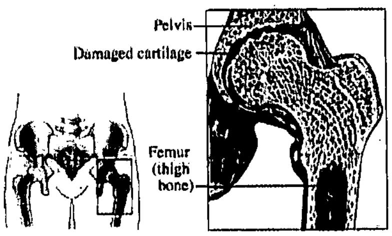
Medha Bharadwaj
Re: Todd Nash
January 3, 2007

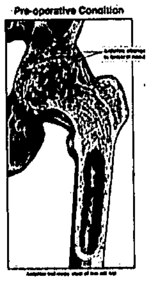
Compare a cross-sectional illustration and femoral-head to acetabulum of normal healthy hip


Pelvis
Cartilage
Femur (thigh bone)


Acetabulum (hip socket)
Femoral head
Femur (thigh bone)
Anterior (front) view of the pelvis

TO **cross-sectional illustration and femoral-head to acetabulum of an osteoarthritic diseased hip with severe dysruption of the surface, as Todd has**


Pelvis
Damaged cartilage
Femur (thigh bone)


Pre-operative Condition

Consistent with the advanced radiologic disease findings, on 8/8/2003, Dr. **Tohidi,** clinically noted the following on physical examination:

> "Extremities: The gait is antalgic inconspicuously.[5] He also has a slightly intoed gait. On the standing position he has bilateral flatfeet with metatarsus abductus deformity, mild.
>
> There is marked limitation of motion to the left hip with 0° of external rotation, about 30° of internal rotation, 25° of abduction, 15° of adduction, and no flexion contractive but flexion of only 50°. He also has slight shortening to the left hip.

(TN_2APP0079 - 80).

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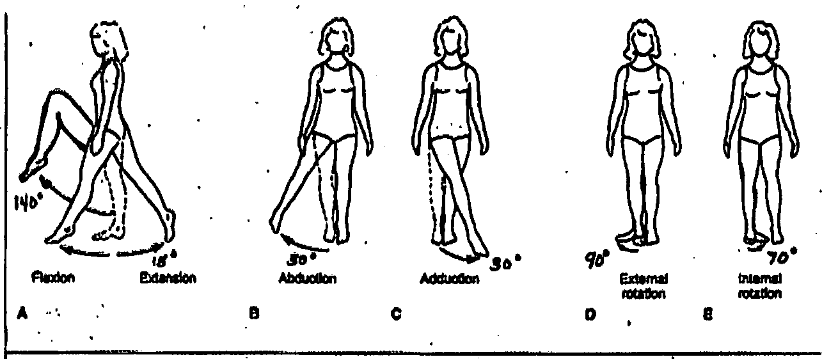
[5]An "antalgic gait" refers to an altered or abnormal posture or gait produced by pain in the affected limb or side. The amount of weight applied to a painful limb or joint and the amount of time that weight is applied are both minimized. The result is a limp, a decreased single support time for the affected limb, a shortened stride length for the contralateral limb, and an increased double support time. [6]Toeing in is caused by an anteverted hip.

Pressed to their normal limits of ranges of motion of the hip, the normal hip joint motion in the normal hip takes place in all three planes. There are: flexion-extension (0-140° flexion and 15° extension), abduction-adduction (0-30°/45°), and internal-external rotation (0-90°/0-70°) respectively). The range of motion in three planes during common daily activities such as tying a shoe, sitting down on a chair, rising from it, picking up an object from the floor and climbing stairs was measured. As reflected in the brief table above, the values obtained for these common activities indicate that hip flexion of at least 120° and abduction and external rotation of at least 30° are necessary for carrying out daily activities in a normal manner. (Nordin M, Frankel V. Biomechanics of the Hip. *Biomechanics of the Musculoskeletal System, 2001*, Panjabi M, and White A. eds.). Functional ROM just to sit down and get back up requires 104° flexion, 17° rotation and 20° abduction.



Movements of the hip joint. A, Flexion-extension. B, Abduction. C, Adduction. D, External rotation. E, Internal rotation.

Range of Motion of the Hip Joint. (Nordin M, and Frankel V. 2001).

The hip ranges of motion required for daily activities carried out in a normal way are

120° forward flexion;
13° backward flexion;
45-60° abduction;
30° adduction;
45° external (lateral) and internal (medial) rotation

Although Mr. Nash already provided you with the normal motion values in his first appeal. (TN_2APP 0135: appeal p.4 of 54, and TN_2APP0214 from Exhibit 2 "Fundamentals of Joint Motion Measurement"), the above picture may help you 'visualize' the motions. In any event, while Todd's range of motion was severely reduced as measured and as experienced clinically from September 2003 forward, it is the bone on bone pressure and grinding **producing excruciating pain** and his resulting intolerance to prolonged sitting and standing and need for frequent rest periods and reclining that preclude him from performing the material duties of his or any sedentary occupation, in addition to his other limitations.

The hip joint is subjected to many various large forces. These forces are created by, for instance • the body weight itself, • the muscle forces around the hip, • and in the ambulatory and normal patient, the strike force of walking or running.

- The estimated load on the normal femoral head in the stance phase of walking is at least 3-6 times the body weight.
- Stair climbing and rising from a low chair with the body bent forward at 100° yields loads of 5.5 times the body weight. (Nordin and Frankel, 2001).
- However, when lifting, running or jumping, the load on the normal femoral head may be equivalent to *10-12 times the body weight.* (Harkess JW, 2001)

Please note that the above measurements are those of a normally structured, shaped and nondiseased hip.

In the severe osteoarthritic hip such as Todd's, however, with deformation of the head of the femur, total obliteration of cartilage (bone-on-bone) damage to the acetabulum, and the presence of bone spurs, the surface area for the weight-bearing load is altered, which misdirects the forces, and the bone-on-bone grinding (especially with prolonged position or activity) produces such pain that cessation or complete avoidance of the activity or position is required. I.e., activity or position tolerance is also lost. Entire textbooks and thousands of articles have been written about post-traumatic or degenerative osteoarthritis.

With respect to the 8/8/2003 visit, Dr. Tohidi overread the X-ray, from which he, like Dr. Schmitter, diagnosed the following:

> The x-rays elicit severe posttraumatic degenerative arthritis of the left hip with congruent loss of the articular space and bone-on-bone contact in the weight-bearing dome and in zone 3 of the acetabulum. The patient otherwise elicits with type-B bone in the proximal femur.

(TN_2APP0079 - 80). Todd has radiological and clinical advanced/severe osteoarthritis with dramatic functional limitations. Note also that Todd has bilateral knee instability, having previously undergone reconstruction of the ACL with graft on the right knee 15 to 20 years ago. Both of his knees are unstable. (TN_2APP 0079 - 0080).

Treatment considerations of August 2003 included conservative management with periodic intra-articular injection of with Xylocaine and Depo-Medrol (with long-term observation to determine the nature and extent of beneficial effect, if any, of the injection) following an initial diagnostic and therapeutic injection at that time.

A week later, **8/14/03**, Dr. Tohidi saw Todd in follow up for the *standing* radiographic AP hip views elicited

> "**severe degenerative arthritis** of the left hip with **complete loss** of the articular space and **bone-on-bone contact**" and that "due to severe anteverted hips, he elicits 155° to 160° of femoral neck and shaft angle, which predisposes him to slight lateral subluxation of the hip bilaterally.

TN_2APP0077.

On **9/5/2003**, Todd again followed up with Dr. Tohidi, who documented that the injection provided only short-lived pain relief. Dr. Tohidi explained the only other conservative alternative:

> He is not able to take anti-inflammatory drugs, and he has not been able to reduce his hip pain with acetaminophen. If he takes narcotics for pain control, he is not in a cognitive state that allows him to perform his job or operate a vehicle in order to get to and from work or, especially while in a foreign country to operate a motor vehicle or seek other transportation while performing his work duties.[7]
>
> . . . At this time it is obvious that the Injection did not provide any long-term improvement and therefore, **symptomatic treatment and activity modification** versus a hip replacement **would be the options of treatment**. Presently, he does not wish to proceed with a total joint considering his age. He will eventually need such a procedure, but I would recommend that he wait until his symptoms are more severe and more disabling.

TN_2APP 0077. Five days later (9/10/2003), Dr. Tohidi prescribed 40 Hydrocodone/APAP 5/500 TAB. Hydrocodone: We did not see any pharmaceutical information related to Hydrocodone in the file, and therefore must assume you are aware of the nature and effects of this potent drug.

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[7] Note: even if Todd were not allergic to anti-inflammatory drugs, such as Todd's ability to take most non-steroidal anti-inflammatory drugs (NSAIDS) such as Naprosyn, Vioxx, and Celebrex, "anti-inflammatory medications (...Non-Steroidal Anti-Inflammatory Drugs) are effective in treating the [earlier stage or] "inflammatory" aspect of either rheumatoid or osteoarthritis." Huddleston, at Arthritis of the Hip Joint, Exhibit TN_2APP 1330-1442 hereto. http://www.hipsandknees.com/hip/hipdisease.htm (2 of 2) 11/24/2003 3:56:13 AM. Moreover, in Mr. Nash's case, as was pointed out in his 5/15/06 appeal at p. 5, 7-8, 13 and 15 and clearly reflected in his medical records, Todd experienced no pain relief in his hip using steroidal anti-inflammatories such as acetaminophen.

Hydrocodone or dihydrocodeinone is a semi-synthetic opioid derived from two of the naturally occurring opiates, codeine and thebaine. Hydrocodone is an orally active narcotic analgesic and antitussive. [8] Todd takes the tablet form.

Well-recognized common side effects of hydrocodone include, among other, dizziness, lightheadedness, drowsiness and mental fogginess.[9] Individuals who must take the drug are advised not to drive or perform activities that might produce injury/be dangerous.

Because Hydrocodone is also well recognized to be habit-forming and lead to physical and psychological addiction, patients who can only achieve some pain relief from opioids due to either an inability to take analgesics, as in Todd's case, or where analgesics are ineffective in relieving the pain, must do what they can to avoid the activities or postures that produce significant pain which would require the use of the opioids. I.e., the patient must avoid activities that produce the severe prolonged pain that would result from engaging in those activities.

Two weeks later, on **9/26/2003**, Todd again saw Dr. Tohidi **due to intolerable pain that results whenever "he is confined to sitting for a prolong period."** (This includes whenever he is in meetings where he must sit for some time, and also when he travels.)

> "He has reached the point where he is **unable to withstand the extent of the pain and remain functional at his present job description**."

TN_2APP 0076. Dr. Tohidi was and is clearly aware of the occupational requirements of Todd's occupation.[10]

---

[8] Hydrocodone is marketed as **Vicodin**, Anexsia, Dicodid, Hycodan, Hycomine, Lorcet, Lortab, Norco, Novahistex, Hydroco, Tussionex, Vicoprofen. Dr. Tohidi prescribes Vicodin for Mr. Nash. See Wikipedia free encyclopedia. http://en.wikipedia.org/wiki/Hydrocodone

[9]Some less common side effects are allergic reaction, blood disorders, changes in mood, anxiety, lethargy, difficulty urinating, spasm of the ureter, irregular or depressed respiration and rash.

[10]Dr. Tohidi's 9/5/2003 report states:
"His work as vice president in business development in his company requires attending many meeting at both customer locations and within the company's own offices. Meetings can last for several hours with limited breaks and very limited opportunity to move about or reposition himself to avoid pain. Of course, when aboard an airplane he sits anywhere from 90 minutes to in excess of 12 hours. He also, especially when traveling, has to board public transportation such as buses or passenger vans or trains and has to sit for anywhere from 30 minutes to in excess of three hours

Total Disability and Short Term Disability Claim

Dr. Tohidi determined that Mr. Nash was totally disabled on and after **September 26, 2003,** completed the disability questionnaire (TN_2APP 0007) and indicated the need to periodically follow Todd's progression for the determination of when a total hip was required.

Dr. Tohidi advised LINA that "therapy" would be of no benefit to Todd because of his condition and its cause.

Todd's salary as of 9/2003 was $151,424.00. He was a "Class 1" insured under the policy.

LTD Policy Definitions:

Under the LTD Plan, an employee is considered Disabled if, solely because of Injury or Sickness, he or she is either:

1. Unable to perform all the material duties of his or her Regular Occupation or a Qualified Alternative; **or**
2. Unable to earn 80% or more of his or her Indexed Covered Earnings.

After Disability has lasted 30 months, you are considered Disabled if, solely due to Injury or Sickness, you are either:

1. unable to perform all the material duties of any occupation for which you are, or may reasonably become, qualified based on education, training or experience; or

2. unable to earn 80% or more of your Indexed Covered Earnings.

TN_2APP 0703 (Policy page 6).

Regular Occupation: is defined in the definitions section as

> "[t]he occupation the Employee routinely performs at the time the Disability begins. In evaluating the Disability, the Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy.

Qualified Alternative: is defined as an occupation that meets all of the following conditions:

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without being allowed to move around adequately. Driving a vehicle for anything over 30 minutes produces increased hip pain. He states that his job has recently demanded that he travel much more frequently and for much longer distances such as International travel than he previously had to do, and he is finding It increasingly difficult because of his hip pain." TN_2APP 0077

1. the material duties of the occupation can be performed by the Employee based on his or her training, experience or education;
2. it is within the same geographic area as the Regular Occupation the Employee holds with the Employer on the date the Employee's Disability begins;
3. a job in that occupation is offered to the Employee by the Employer; and
4. the wages for that occupation, including commissions and bonus are 80% or more of the Employee's Indexed Covered Earnings.

As defined in the "Definitions" section, **"Indexed Covered Earnings"** for the first 12 months Monthly Benefits are payable are the employee's Covered Earnings.

Mr. Nash's Covered Earnings, with his 20-year history in the business and being a key employee, were $151,424.00 ($12,618.66 per month). LTD benefits are sixty percent (.60) of his Covered Earnings, which is $90,854/year ($7,571.20/mo.).

Then the policy provides:

"After 12 Monthly Benefits are payable, your Indexed Covered Earnings are your Covered Earnings **plus an increase applied on each anniversary of the date Monthly Benefits became payable**. The amount of each increase will be the lesser of:

1. 10% of your Indexed Covered Earnings during your preceding year of Disability; or

2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

(Bold / underline added).

Beginning with the first anniversary monthly benefits became payable, Todd's $12,618.66 (predisability) Covered Earnings are upwardly adjusted by the rate of increase of the CPI-W, and are adjusted annually thereafter by each successive CPI-W. After the first anniversary of benefits payment, the employee must be able to earn 80% of the Employee's *Indexed Covered Earnings* for that date. Indexing of the Covered Earnings should have occurred on 3/28/05, resulting in an Indexed Covered Earnings of approximately $13,046.18, according to the Bureau of Labor Statistics easy calculator, and again on 3/28/06 of the 2005 value, to approximately $13,460.34.[11]

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[11] We note that Todd had calculated the Indexing as of November 30, 2005, as $12,948, and $13,404/mo. as of 2006.

Eighty percent (80%) of the above Indexed Earnings are as follows:

$12,618.66 x .80 = $10,094.92 (3/28/04)
$13,046.18 x .80 = $10,436.94 (as of 3/28/05)
$13,460.34 x .80 = $10,768.24 (as of 3/28/06).

Todd was unable to perform all of the material duties of his regular occupation; unable to perform prolonged positional (particularly sitting) and nonexertional requirements of his sedentary occupation and was restricted from lifting over 10 pounds occasionally during the day. His employer advised could not accommodate the level of his impairments and limitations. (E.g., TN_2APP0952). Being limited to about 2.5 hours upright sitting spread out in interrupted periods, interspersed with rest periods etc., over the period of an 8 hour day compared to that which is required by a sedentary occupation (approximately 5.5 hours prolonged continuous required daily sitting, among other bending and lifting and stooping etc. requirements, and 2.5 hours of standing and walking, Todd would also be unable to earn anywhere near 80% of the indexed predisability earnings ($10,500 -10,700 per month at the time of the claim termination).

Under the Plan, after a 14-day STD "elimination period," employees are eligible to receive up to 26 weeks STD benefits, whereafter the claim automatically changes to a Long Term Disability (LTD) Claim.

Todd submitted his Notice of Claim and submitted completed claim forms at LINA's request. The policy states that after LINA receives notice of the claim, it will send the claim forms for the filing of proof of loss. The policy's "Proof of Loss" section (at policy p. 23) states:

> You must provide written proof of loss to us, or proof by any other electronic/telephonic means authorized by us, within 90 days after the date of the loss for which a claim is made. If written proof of loss, or proof by any other electronic/telephonic means authorized by us, is not given in that 90 day period, the claim will not be invalidated nor reduced if it is shown that it was given as soon as was reasonably possible. . . .
>
> Written proof that the loss continues, or proof by any other electronic/telephonic means authorized by us, must be furnished to us at intervals we require. Within 30 days of a request, written proof of continued Disability and Appropriate Care by a Physician must be given to us.

Interestingly, the latter provision related to the date by which written proofs of the continuation of the insured's disability must be provided appears to have simply replaced the language which is required by California law. Insurance Code §10350 requires the compulsory "Proofs of loss" language of §10350.7, among other, to be included in disability policies if some alternative wording is provided which is less favorable in any respect.[12] The policy's requirement that written proof of continuing loss must be submitted within 30 days of a request is certainly less favorable than the 10350.7 provision, thus, 10350.7 is also read into the policy.[13] Insurance Code-required policy language takes precedence over any non-required policy provision. Galanty v. Paul Revere Life Ins. Co., 23 Cal. 4th 368, 1 P.3d 658 (2000).

That aside, Todd has at all times been diligent in providing as soon as possible all written proofs that LINA has requested.

On **10/14/2003**, LINA acknowledged and concurred in Todd's total disability, STD payments beginning on 10/13/2003 (the end of the 14-day elimination period).[14]

LINA's *"Physical Abilities Assessment Form"* (**PAA**) provided to Dr. Tohidi reflects Dr. Tohidi's **November 2003** assessment of Todd's limitations and restrictions. Dr. Tohidi checked the box indicating that Todd's capabilities for **sitting** were **less than 2.5 hours in 8-hour day**, and that Todd experiences

> "severe L hip pain when sitting in a confined area as a chair or airplane seat, walking over 1/4 mile, standing & climbing stairs. L hip limited motion precludes stopping & crouching. Hip pain occurs in 10-90 minutes with the above activities."

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[12]California Insurance Code § 10350, **"Application of article"** :
". . . each disability policy delivered or issued for delivery to any person in this State shall contain the provisions specified in Sections 10350.1 to 10350.12, inclusive, in the words in which the same appear in such sections; provided, however that the insurer may, at its option, substitute for one or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in each section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve. [underline added]

[13]California Insurance Code § 10350.7 **"Proofs of loss"**
"A disability policy shall contain a provision which shall be in the form set forth herein."
"**Proofs of Loss**: Written proof of loss must be furnished to the insurer at its said office in case of claim for loss for which this policy provides any periodic payment contingent upon continuing loss within 90 days after the termination of the period for which the Company is liable." Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity, later than one year from the time proof is otherwise required." [underline added].

[14] STD weekly benefits were $1,747.00 offset by $602.00 California State Disability Insurance (SDI) benefits, for a total of $1145.00.

Dr. Tohidi checked "**less than" 2.5 hours capability over an 8-hour day for standing and walking**, and reaching overhead or at a desk level.

Dr. Tohidi also restricted Todd (checked "**no**") from climbing, balancing, crawling, crouching, stooping, extended work hours, exposure to vibration, or below-the-waist reaching due to Todd's severe range of hip motion limitations.

Dr. Tohidi also checked the box of "sedentary" "strength" category for work that was limited to 10 pounds "occasionally." TN_2APP0009 - 10.

On **12/29/2003**, Dr. Tohidi confirmed that Todd remained under his care for severe osteoarthritis, and (consistently) reported his opinion of Todd's severe condition TN_2APP0967.

2004:

Dr. Tohidi again saw Todd on **1/14/2004** for examination and prescription refill of Vicodin. (The prescription refill records are at his first appeal Exhibit 15, TN_2APP0358-370). Todd's hip deterioration and associated clinical presentation was, not surprisingly, unchanged:

> . . . his **hip condition is essentially the same** and that he more or less has **pain all day, which is aggravated with the various levels of activity**. He specifically states that **sitting is quite painful for him, and after about 30 minutes** the pain becomes intolerable, forcing him to move around.
>
> Therefore, it is obvious, in my opinion, that **no further change at this time could be implemented in his activity status or his job description.**
>
> . . . to clarify the records, In my opinion the restrictions that he has are **limitations of sitting and his tolerance on a subjective and objective basis, is about 30 minutes**, following which .he needs to move around to relieve the intensity of the pain. He also **has limitation in mobility, such as prolonged standing or walking. A more detailed description of his limitations was addressed in a job analysis form, which also needs to be considered as part of his restrictions.**
>
> Because of the intensity of his pain, I had prescribed for him **narcotic analgesics** that he takes periodically when the pain is severe enough that it interferes with his functions of daily living and also sleep. Therefore, based on that aspect of his treatment, he is also restricted In performing any activity that might become hazardous to him while he is taking the narcotic analgesics.

> As far as the objective aspects of his hip condition are concerned, as mentioned previously, he has **significant limitation of range of motion to the hip with stiffness and an antalgic gait, with radiographic and clinical evidence of endstage hip osteoarthritis.**
>
> Since he is presently taking narcotic analgesics periodically, this is an issue that likely will be continuous on long-term basis as part of the treatment for him. He is limited as far as cognitive functions are concerned in regard to the effect of narcotic analgesics.
>
> The eventual treatment for Mr. Nash, as I had mentioned previously, is a total hip replacement, which has a finite life and obviously, because of his age, that treatment has been reserved to be applied in the future. I would therefore recommend that Mr. Nash be followed periodically, and I will see him again in three months

TN_2APP 0074 - 75. See also Dr. Tohidi's letter. TN_2APP 0908 and see the updated PAA form of 1/16/2004. TN_2APP 0012 - 13.

On **1/16/2004**, Dr. Tohidi completed yet another PAA form for LINA.

Dr. Tohidi indicated on the 1/16/04 PAA form, as before, that Todd continued on Vicodin for his pain treatment, that narcotic pain medication effects preclude the necessary level of cognitive function for the occupation, and that the specific restrictions placed on him included

- that he was "not [to] perform activities that may become hazardous while taking narcotics,"

- that his limited range of motion (ROM) in left hip precludes the ability to perform job functions without significant pain;

- that "throughout an 8-hour workday, the patient can tolerate, with positional changes and meal breaks, the following activities, supported by objective evidence, for the specified duration: less than 2.5 hours sitting, standing, walking, reaching at overhead or desk level (but not below waist), and "occasional" 10 pound maximum lifting or carrying, pushing or pulling, but restricts such activities over 11 lbs.

- that, as before, Todd is not to climb ladders, balance, stoop, kneel, crouch, crawl, work extended shifts, use lower extremities for foot controls.

TN_2APP 0012 - 13.

The PAA form does not include a data inquiry or any request for ROM measurements.

Dr. Tohidi also answered LINA's questions at end-January 2004. He informed LINA that the severity of Todd's hip disease level caused pain with sitting for 15 minutes, but that Todd could sometimes sit for an 1.5 hours (90 minutes) at home where he could slouch and lay down for periods when the pain arises. His condition requires that Todd constantly change what he does, walking, laying, sitting to help manage the pain. He reiterated that Todd's ROM is significantly decreased and that he suffers constant pain and cannot even bend over to put socks on or tie his shoes. TN_2APP 1015.

As mentioned above, Vicodin and other narcotic agents of the same type are well known to cause impairment of cognition affecting attention, concentration, and can impairs motor function and reaction time while on the drug, making it inadvisable to drive and perform activities that could be dangerous, etc.

Because March 28, 2004 was the end of the 26-week STD period, LINA began its (own-occupation) LTD investigation 1/29/2004 in advance of the upcoming date.

On **March 16, 2004,** LINA advised Todd that LTD benefits for disability from his own occupation under the terms of the Plan was granted effective 3/28/2004. TN_2APP 0923 - 925.[15] LINA explained that LTD benefits are payable while Todd is under the care of a licensed physician, that LINA would request periodic updates on the status of his disability and reserved the right to have Todd examined by a physician of its choice.

On **5/27/2004**, Todd's refilled his prescription for Vicodin prescribed by Dr. Tohidi.[16]

On or about **6/10/2004**, the Social Security Administration (**SSA**) approved Todd Nash's Social Security Disability Benefits insurance claim. TN_2APP 0352-0355.(Exhibit 13 of his first appeal). The Social Security Act "defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. To meet this definition, you must have a severe impairment(s) that makes you unable to do your past relevant work or any other substantial gainful work that exists in the national economy." 20 C.F.R. § 404.1505(a). In addition, the Social Security analysis of sedentary occupations tracks that of the D.O.T.[17] This is undoubtedly because the D.O.T. was in existence and the working tool when the Social Security analytical process was developed. The finding by the SSA that an individual is disabled from performing any gainful occupation is certainly relevant to the issue of whether the employee is disabled under the much more lenient definition of disability in LINA's policy.[18] The Social Security 'any other substantial gainful work' definition of disability is much more difficult to meet than inability to perform the material duties of one's own occupation.[19]

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[15]LINA also stated, "If we determine that you are a suitable candidate for rehabilitation, we may require you to participate in a Rehabilitation Plan. We have the sole discretion to approve your participation in a Rehabilitation Plan and to approve a program as a Rehabilitation Plan. The Rehabilitation Plan may, at our discretion, allow for payment of your medical expenses, education expenses, moving expenses, accommodation expenses or family care expenses while you participate in the program. . . ." No Rehabilitation Plan was ever prepared, proposed, or provided to Mr. Nash. Given the nature of his severe bone-on-bone osteoarthritis causing inability to perform prolonged sitting or standing or lifting above 10 pounds, which will not go away through any "rehabilitation plan," this was not surprising.

[16] 50 Hydrocodone/APAP 5/500 TAB

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[17] 20 C.F.R. § 404.1567. Sedentary work involves:

> lifting no more than 10 pounds at a time, and occasionally lifting or carrying articles like docket files, ledgers and small tools. Although a sedentary job is defined as one which involves sitting, a certain amount of walking and standing is often necessary in carrying out job duties. Jobs are sedentary if walking and standing are required occasionally and other sedentary criteria are met.

Social Security Ruling 83-10, like the D.O.T., defines "occasionally" as "occurring very little up to one-third of the time." "Periods of standing or walking should generally total no more than about 2 hours of an 8-hour workday, and sitting should generally total approximately 6 hours of an 8-hour workday."

In addition, the Social Security Commissioner has expressly stated that **a person who is unable to sit for prolonged periods of time is incapable of engaging in the full range of sedentary work**. SSR 83-12 ("In some disability claims, the medical facts lead to an assessment of [Residual Functional Capacity] which is compatible with the performance of either sedentary or light work except that the person must alternate periods of sitting and standing. The individual may be able to sit for a time, but must then get up and stand or walk for a while before returning to sitting. Such an individual is not functionally capable of doing either the prolonged sitting contemplated in the definition of sedentary work (and for the relatively few light jobs which are performed primarily in a seated position) or the prolonged standing or walking contemplated for most light work."). Pursuant to these rulings and regulations, it is true that "**to be physically able to work the full range of sedentary jobs, the worker must be able to sit through most or all of an eight hour day.**" *Aukland v. Massanari* 257 F.3d 1033 (9th Cir. 2001) citing *Tackett,* 180 F.3d at 1103 (emphasis added). This principle is a long-standing principle of disability law. *Farrow v. Montgomery Ward Long Term Disability Plan*, 176 Cal. App. 3d 648; 222 Cal. Rptr. 325; 1986 Cal. App. LEXIS 2466 (1986) (The Ninth Circuit observed: ". . . the medical evidence and claimant's testimony depict an individual who cannot sit, stand or walk for any length of time without severe pain, and who must alternate periods of sitting, standing and walking throughout the course of each day. 'A man who cannot walk, stand or sit for over one hour without pain does not have the capacity to do most jobs available in the national economy.' *(Citing Delgado v. Heckler*, 722 F.2d 570, 574 (9th Cir. 1983)." (*Gallant v. Heckler*, supra, 753 F.2d 1450, 1454.). . . the Secretary issued a '**Program Policy Statement.' SSR 83-12 Unempl.Ins.Rep. (CCH) (New Matters) para. 14,533 (1983).** Under the heading '**Special Situations**,' the statement discusses the impact of a finding that the claimant must alternate periods of sitting and standing. Such a claimant is defined as functionally not capable of doing either the prolonged sitting contemplated in the definition of sedentary work or the prolonged standing or walking contemplated for most light work".)

[18] *Stith v. Prudential Ins. Co.* ,2005 U.S. Dist. LEXIS 2000 (D. NJ Feb. 14, 2005); *Moon v. Unum Provident Corp.*, 405 F.3d 373, 379 (6th Cir. 2005); *Newman v. Reliastar Life Ins. Co.*, 2005 WL 1521399 (M.D. PA 2005); *Nickola v. CNA Group Life*, 2005 U.S. Dist. LEXIS 16219 (N.D.IL Aug. 5, 2005); *Klimas*

The above long-standing insurance law principles govern individual and group disability determinations as well as SSA determinations.[20]

On **11/8/2004**, Todd saw his Primary Care Physician, Stacey Lin, M.D. who, with respect to Todd's "severe osteoarthritis," noted "tenderness to palpation, not only on the left hip around the femoral head but his range of movement is only able to lift his knee up off the table about five degrees. TN_2APP 0098.

2005

Dr. Tohidi again examined Mr. Nash on **1/4/2005** and reported:

> His hip discomfort and pain remain the same. He has **difficulty sitting** and **has developed more stiffness** to his hip. He is essentially unable to sit normally in a chair and has to sit more or less with his hip flexed no more

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v. Connecticut General Life Ins. Co., 2005 U.S. Dist. LEXIS 18555 (E.D. PA 2005); *Buzzard v. Holland*, 2004 U.S. App. LEXIS 8170 (4th Cir. May 17, 2004); *Saliamonas v. CNA, Inc.*, 127 F. Supp. 2d 997, 1000 (N.D. Ill. 2001); *Reipsa v. Metropolitan Life Insur.Co.*, 2002 U.S. Dist. LEXIS 13188 at *18-19 (N.D. IL June 11, 2002); *Halpin v. W.W. Grainger, Inc.*, 962 F.2d 685, 695 (7th Cir. 1992); *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1566 n.11 (11th Cir. 1990); *Glenn v. MetLife*, 2006 U.S. App. LEXIS 22432, *20-21 (6th Cir. Sept. 01, 2006).

[19] *Glenn v. MetLife*, 2006 U.S. App. LEXIS 22432, *20-21 (6th Cir. Sept. 01, 2006).

[20] *Seitz v. Metropolitan Life Ins. Co. (& Merck & Co., Inc., Medical, Dental, and [LTD] Program for Non-Union Employees)*, 433 F.3d 647 (8th Cir. 2006); *Smith v. Cont'l Cas. Co.*, 369 F.3d 412 (4th Cir. May 28, 2004), involving an insured suffering from degenerative disc disease, bilateral laminectomies at L3-4, 4-5, spinal stenosis and subsequent failed back syndrome, *Tippitt v. Reliance Standard Life Ins. Co.*, 457 F.3d 1227, 1236 (11th Cir. 2006), which involved a group insured with disabling symptoms of, among other, joint pain, back pain, and hip pain, reporting "pain in multiple joints, particularly in his hips, and reported that his activity levels were increasingly restricted." In order to perform a job satisfactorily, to carry out its [material] duties, a worker must be able to perform the tasks it requires from the beginning to the end of the work day. Otherwise, he cannot perform its tasks or carry out its [material] duties. This is another way of saying that the duty of a job is to perform its tasks as many times, and as long throughout the work day, as the job requires.

> than about 50°. [fn21] His gait remains antalgic, and he does limp because of the painful left hip. Indeed, range of motion **[ROM] has lessened** and he does elicit **significant pain with any active or passive motion**.
>
> He is managing his pain on a conservative level, and obviously he will require a total hip replacement in the future when his pain becomes more or less unbearable. . . . He will need to be followed periodically. . .

TN_2APP 0073. The next day, Dr. Tohidi provided a prescription refill of 60 Hydrocodone/APAP 5/500 TAB.

At LINA's request, Dr. Tohidi filled out another Form on **3/31/2005**, checking (☒) that Mr. Nash's condition was "Unchanged" and that he was an occupational "Class 5 - severe limitation of functional capacity; incapable of minimal (sedentary) activity, writing,

> "Limited Range of Motion in Left hip precludes ability to perform work activity without significant pain. Prescribed narcotic pain medication precludes cognitive function . . . . Patient continues to be disabled for any occupation."

Dr. Tohidi also checked (☒) that: Todd was not a candidate for further rehabilitation services; that his present job cannot be modified to allow for handling it with impairment; that "vocational counseling and/or retraining" would not be recommended. TN_2APP 0014 - 0015.

We note that on 8/30/2005, Mr. Eccles wrote that the policy's 'any gainful occupation' tier of the disability definition was to begin 3/29/2006 (TN_2APP 0846) and asked Todd to complete a questionnaire form as part of the investigation of that period. As mentioned above, the policy definition for this period states:

> "After Disability has lasted 30 months, you are considered Disabled if, solely due to Injury or Sickness, you are either:
>
> 1. unable to perform all the material duties of any occupation for which you are, or may reasonably become, qualified based on education, training or experience; **or**
>
> 2. unable to earn 80% or more of your Indexed Covered Earnings."

However *before LINA received the completed questionnaire form* from Todd, Mr. Eccles sent the file to LINA's SIU department (Special Investigations Unit) for a 10–day period starting 9/22/2005.

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[21] compared to normal forward flexion of 120°

Todd returned his completed Questionnaire form **9/23/2005**. On it, he indicated that he could drive about 45 minutes, and answered questions about activities listed on the form (listed is: cook, clean, shop, laundry, yard work, gardening, read, watch TV, other) he did "*regularly*" and whether he goes for walks. TN_2APP 1241-1244. Interestingly, on 9/28/2005, the SIU ordered surveillance.[22]

On 10/19/2005,[23] Dr. Tohidi completed another LINA PAA repeating what he had advised LINA of ever since September 2003, i.e., that:

> **"Mr. Nash has severe L hip pain when sitting in a confined area as a chair or airplane seat, walking over 1/4 mile, standing and climbing stairs, L hip limited motion precludes crouching. Hip pain occurs in 10-90 minutes with the above activities. Anti-inflammatory meds and ASA have not been remedial. Narcotics preclude cognitive function.**

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[22]Of concern is the fact that the documents pertaining to the referral to the SIU, as well as the SIU's assignment for surveillance, and all communications regarding that process, have been concealed or deleted from the claim file version sent to Mr. Nash. Please obtain that complete SIU file and include it in the claim file records and forward a copy to us. Under the ERISA claim regulations, LINA had an express obligation to furnish all pertinent documents regarding this claim.

29 C.F.R. § 2650.503-h(2) states, among other: "(iii) ...a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, ***all*** documents, records, and other information *relevant to* the claimant's claim for benefits. Whether a document, record, or other information is *relevant to* a claim for benefits shall be *determined by reference to paragraph (m)(8)* of this section."

Subsection (m)(8) states : "a document, record, or other information shall be *considered ``relevant" to* a claimant's claim if such document, record, or other information

(i) was relied upon in making the benefit determination;

(ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination

(iii) demonstrates compliance with the administrative processes and safeguards required pursuant to paragraph (b)(5) of this section in making the benefit determination;. . . ."

Subsections (h)(3), (4) and (i)(5) are pertinent including (j)(5)'s furnishing documents, which provides:

"In the case of an adverse benefit determination on review, the plan administrator shall provide such access to, and copies of, documents, records, and other information described in paragraphs (j)(3), (j)(4), and (j)(5) of this section as is appropriate," which contains the same requirements as before.

[23] This shortly after Dr. Tohidi had resumed his medical practice in Georgia, having moved from California in or around August/September 2005.

Again, the PAA forms do not include a request for any specific tests or measurements. That would need to be requested, per the contract, separately. LINA sent no separate request for any particular measurements or other tests to Todd.

Prior to the receipt of this information, however, LINA arranged for surveillance to follow and surveil Todd from **October 25-29, 2005** —a week after Dr. Tohidi's **10/19/2005** PAA form completion (TN_2APP 0016- 0017).

The surveillance video and the surveillance report dated **11/7/ 2005**, and the contentions made by the surveillance company and adopted by LINA regarding it (TN_2APP 0538-0555; 0532-0538; 0650-0669), formed the basis for LINA's December 13, 2005 termination letter, which Todd addressed at length in his first appeal.

> (NOTE: It is apparent from the file that LINA did not provide a copy of the selected footage excerpts nor of the report and request their comment, and first hand input from Mr. Nash on "activities" that were truly speculative and, in fact, incorrect (such as the absolutely erroneous contention Mr. Nash must be employed at a winery).
>
> Nor was a copy of it first provided to Mr. Nash's physician(s) for comment as to whether it reflected the types of movement, stiffness, antalgic gait or limping or ranges of motion they had personally tested.
>
> Prior to using it to terminate the claim, there simply appeared to be no communication at all about the surveillance report and footage with Mr. Nash or his physicians, leaving him the only alternative of having to 'appeal' the denial and that basis. Although Mr. Nash made *great* efforts to obtain a copy of the original unedited surveillance tape related to his claim, he was never able to obtain it. He was only, after the denial, provided with selected excerpts.

Todd's appeal refuted the assertions and mischaracterizations of his "activities" on the tape and report. See his appeal
pp.26-35 of 54 (TN_2APP 0157-0166),
pp. 36-39 of 54 (TN_2APP 0167-0170), and
pp 45 of 54 (TN_2APP0176);
See also Exhibits to his appeal addendum:
Exhibit 1 of addendum (TN_2APP 0192-0208);
Exhibit 25 of addendum (TN_2APP 0424-438);
Exhibits 27-28 of addendum (TN_2APP0446 - 0471);

Exhibit 29 of addendum (TN_2APP0472-0492);
Exhibit 30 of addendum (TN_2APP0493–0494).[24]

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[24]***Carugati*** *v. The Long Term Disability Plan for Salaried Employees*, 2002 WL 441479, at *7 (N.D. Ill. March 21, 2002) (holding that the surveillance video "does not shed light on [the plaintiff's] ability to function at a full-time job"); ***Clausen*** *v. Standard Ins. Co.*, 961 F. Supp. at 1457 (noting that the video surveillance showing the claimant walking her dog two miles and driving a car, reveals nothing suggesting that the plaintiff was "capable of such activity on a sustained basis or that the documented anything other than a good day or a special day visiting her mother"; the claimant's ability to sustain physical activity is typically an important aspect of evaluating their ability to perform a given occupation. *Id.* at 1457. Where plan defines "disability" as being "unable to perform with reasonable continuity the material duties of your own occupation," the surveillance tape had little if any relevance to the standard"); ***Grosz-Salomon*** *v. Paul Revere Life Ins.* Co., 1999 U.S. Dist. LEXIS 22753, 1999 WL 33244979, *5-*6 (C.D. Cal. Feb. 4, 1999) (activities captured on video tape did not shed light on the plaintiff's ability to practice law full time, nor were the activities contradictory of her reported limitations.); ***Thivierge*** *v. Hartford Life & Acc. Ins. Co.*, 2006 U.S. Dist LEXIS 25216 (N.D. Cal. 3/28/2006); ***Mullally*** *v. The Boise Cascade Corp. Long Term Disability Plan*, 2005 U.S. Dist. LEXIS 387 (N.D. IL Jan 11, 2005) (Defendants argue that Plaintiff did activities such as driving her daughter to school, laundry, dusting, dishwashing, cooking, shopping for groceries, and walking. However, "when one is working at home it is easier to interrupt one's work every few minutes if need be than to do so at the office." ***Hawkins***, 326 F.3d at 918. Thus, whether Plaintiff is able to do light household chores is not determinative of whether Plaintiff can work full time." (Citing *Hillock).*) 2004 U.S. Dist. LEXIS 3907, 2004 WL 434217, at *7 (". . . . these activities only reveal that, for limited periods of time, Plaintiff was able to complete certain activities []but] do not demonstrate Plaintiff is able to work full time; . . . [claimant] frequently rested throughout the day."); ***Hillock*** *v. Continental Cas. Co.*, 2004 WL 434217, *6 (N.D. IL. Mar. 2, 2004); ***Sanders*** *v. Hartford Insurance Co.*, 2006 U.S. Dist. LEXIS 21939, *12-13 (D. Ark. 2006); ***Soron*** *v. Liberty Life Assur. Co.*, 2005 U.S. Dist. LEXIS 42972, *30-32 (N.D.N.Y May 2, 2005) ("neither plaintiff nor her doctor claim that she cannot perform tasks for a short period of time or, on good days, any of the activities shown on the surveillance tapes. . . . Nor is it necessary for plaintiff to demonstrate complete incapacitation, or being homebound, to demonstrate disability under the "own" occupation definition in her policy. She only needs to be unable to [*31] perform the substantial and material duties of her occupation which requires at least 40 hours a week in an environment which, however flexible, constrains her physical movements at the same time it requires fine fingering work. She claims that she lacks the stamina to work full-time and is sometimes incapacitated for long periods after short periods of exertion. [¶] The surveillance video cannot be relied on to contradict this reporting because it shows her performing isolated activities for brief periods of time with no revelation of the consequences. . . . [p]atients with rheumatoid arthritis under treatment in this day and age are rarely bed ridden and homebound. They are able to engage in moderate degrees of activity on their good days, but what a hidden camera hidden in the [*32] bushes cannot document is how much discomfort the patient has after these activities, how much time is spent on the couch afterwards, and what amount of pain medication or anti-inflammatory medication is required to manage symptoms"

What became readily apparent to us in our review of this information, and apparently to LINA after his appeal, that the surveillance 'information' contained outright inaccuracies, misleading descriptions and characterizations, assertions of fact that were simply false, and other innuendo and speculations related to the tape not to mention limited activities which did not correlate to the prominent features of his occupation or any other similar type of occupation: that of prolonged sitting all day, full time, five days a week. Although the snippets of recorded periodic 'activity' may demonstrate the patient's ability to perform a specific physical task on occasion, at a given moment or even over a certain segment of a day, nothing in the recording indicated an ability to perform that task on an ongoing or regular basis, does not shed light on the actual ability to function in his or any full-time occupation, and the minimal activities recorded had no relation to the occupational duties at issue.

While Mr. Nash's comments candidly refuted and/or corrected, point by point, in great detail, the many mischaracterizations, inaccuracies, and non-relationship of the limited "activities" seen compared to the actual disabling features of his disease, we recommended that he forward the footage to his treating orthopedist who has seen him for nearly four years now, for his objective comments from the perspective of the examining and treating orthopedic hip specialist. Mr. Nash therefore submitted the surveillance report and the selected footage to Dr. Tohidi, for his review and comment. Dr. Tohidi has examined and followed Todd for at least four years and is intimately familiar with the movements and kinetics and impairments that he has personally observed of his patient. Dr. Tohidi's review comments about the surveillance information is addressed in his letter dated **10/23/2006** (TN_2APP_Ex.005-007).

> Dr. Tohidi's medical observations note that his patient is seen on the video was "walking with a modified gait and deflecting his left leg." He explains that this is seen in advanced hip patients with rather marked hip stiffness, such as Todd has complained of. Dr. Tohidi provided examples of just "a few" of the video images that show the marked limitations of Mr. Nash.
>
> Dr. Tohidi described numerous occurrences of 1) hyperextension of the left leg at the knee joint with back bending to accommodate stiffness ; 2) modified gait that he states is consistent in patients suffering from severe osteoarthritis; 3) stiffness-caused need for the patient to extend the affected (left) leg behind him; 4) the need for the patient to slide objects; 5) lifts without waist bending; 6) patient movements with obvious marked stiffness.
>
> Dr. Tohidi reiterated what is consistently reported in all of the medical records, "This patient has **significant limitations with sitting**."
>
> Dr. Tohidi critically observes that "the video does not show the patient **sitting** except for a few excerpts getting into his car and one clip lasting only a few seconds of him sitting at a table."

Dr. Tohidi also advises in his letter that his patient does have **limitations with standing**. He observed from the tape that

> "When the patient is shown standing for a few minutes he is often shown leaning against a tree, a wall, or other crutch taking weight off his left leg. The patient is not shown positioning his left hip in a way that is inconsistent with his disease and resulting limitations."

He also noted that the video picture was of "poor quality" and "does not clearly show the patient's facial expressions and often is taken from behind." He states that does not allow the viewer to see indications of discomfort on the patient's face.

The observations by Dr. Tohidi of the surveillance information were not limited to the footage itself, but also noted his concerns about the surveillance report that he read in connection with the footage supplied. He states,

> "In my opinion, this report was either prepared by an inexperienced person and/or a person using descriptions intended to describe the patient's movement in an inappropriate way. The descriptions used do not mention what is clearly seen in the video. . . . The descriptions are inaccurate and at best misleading."

This was apparently what LINA determined itself after reviewing Mr. Nash's first appeal, since the surveillance was not a basis for denial as seen by the July 2006 denial letter.

The surveillance "activities" do not show how he would be able to perform the material and substantial duties of any full time sedentary or light occupation and in particular, his own occupation.

/ / /

On **12/19/2005** (which we note is 5 days after Todd was told on the phone his claim was terminated (and 3 days before Todd received the mailed termination letter itself), Todd followed up with his PCP, Dr. Stacey Lin for his next recommended annual follow up. Dr. Lin reported:

> . . . The patient continues to have a **lot of pain, particularly decreased range of motion, only about 5° to lift his knee up off the table**. There is no swelling or edema. He is still on the Vicodin. He avoids taking this medication due to decreased mentation and inability to drive on the medication.
>
> The pain is off and on. He has **good days and bad days.** What is helpful is if he reclines. **Sitting is the worst in that he has pain as well as decreased sensation after about 15 minutes.**
>
> No urinary difficulties; **particularly worse with different activities such as showering or putting on his socks**. He does tell me that his Disability has been discontinued. This is secondary to [alleged] lack of documentation. Apparently, there, is a fax to this office from medical records, but I do not see any record of this fax.

Dr. Lin noted tenderness to palpation along the hip particularly at the left on physical examination, and indicated that he would refer Mr. Nash to Dr. Padilla since Dr. Tohidi had moved to Georgia. TN_2APP 0096 - 0097. Dr. Lin ordered a refill of 50 Hydrocodone/APAP 5/500 TAB for pain.

2006

On **1/6/2006,** Mr. Nash continued his periodic follow up for his (still-severe) hip disease with a new orthopedist, Patrick Padilla, M.D., which he saw on this one occasion.

Dr. Padilla described Todd's "ongoing significant limitation of ROM of the left hip as well as difficulty with foot wear and foot care of the left foot," continued use of Vicodin for pain which is not controlled by avoidance of the postures and activities that produce pain. Physical examination revealed, as it had in the past, unequal leg length (left shorter than right by 1 cm), and significantly limited ROM on the left: 45° forward flexion; internal and external rotation, 0°; 10° abduction with minimal hip extension. Todd underwent a repeat horizontal AP Pelvis and attempted Frog Lateral Left Hip X-ray on **1/4/2006** which Dr. Padilla indicated continued to show

> "severe degenerative arthritis with joint space narrowing, osteophyte formation."

Dr. Padilla concluded that based on Todd's age and disease severity, it was unlikely that conservative treatment (such as oral anti-inflammatories, use of a cane, or intra-articular Corticosteroid injection or even total hip arthoplasty) would produce much gain. TN_2App0118 -0119. This is precisely Dr. Tohidi's opinions in 2004 and 2005. Todd was willing to try Naprosyn, but within 10 days, had to discontinue it due to allergic responses at the recommendation of the pharmacist and Dr. Padilla.

On **2/9/2006,** Mr. Nash was seen by orthopedic surgeon **James A. Helgager, M.D.** of Tri-City Orthopedic Surgery (the office of his prior physician, Dr. Ozerkis). TN_2App0120 - 0121. Dr. Helgager took note of Todd's past medical history of "a right ACL reconstruction many years ago with re-rupture of ACL," and resulting knee instability and, as did the prior above-referenced specialists with respect to the advanced left hip disease, noted Todd's history of non-success with a trial of anti-inflammatories, inability to take aspirin (NSAIDS), and the resulting need to "manag[e] his condition with activity modification and Vicodin." On examination that day, Dr. Helgager noted Todd has a minimal antalgic gait on the left with (continued) marked restriction of left hip motion, with only 70° flexion, minimal rotation, and 10° of both abduction and adduction, and an "inability to sit without reclining back because of the stiffness of his left hip." As to the most significant disabling factor for Mr. Nash, Dr. Helgager also explained:

> "the patient cannot sit in a chair for any significant period of time and thus is not able to work."/ "Patient is not capable of working at his previous job because he is unable to sit either in a chair or plane because of pain and because his hip is so stiff he is not able to sit upright and must recline."

TN_2App0120 - 0121.

On **2/13/2006**, Mr. Nash followed up with his PCP, Dr. Lin. Dr. Lin states,

> I do not have Dr. Helgager's note at my office at the time of this time dictation. I do, however, have Dr. Padilla's note from his evaluation on January 4. It looks like from Dr. Tohidi's notation as well as Dr. Padilla's examination that there has been no significant change in the patient's condition at least from January 2005. It does look like Dr. Padilla had his forward flexion only at 45°. He is sitting a bit leaned back today in the room to about 70°, and he does tell me that Dr. Helgager gave him a 70° range of motion. It sounds like the plan, according to the patient, with Dr. Helgager is to maintain his current regimen and his current activity plan. He [Mr. Nash] is unable to sit for prolonged periods of time given the significant limitation of range of motion of his left hip. It does look like his job description, however, requires him to sit for: significant amounts of time. This patient has asked me to fill out a physical abilities assessment form. We did go over this today. It looks like there has been no change from his previous visit with Dr. Tohidi. . . . . I recommended that the patient stay at his activity level . . . . Given his level of pain and limitations, it does not look like he is able to significantly sit, bend, walk, kneel, or reach, and especially any sort of what looks like extended hours.

Dr. Lin's PAA form of **3/13/06** similarly checked off LINA's boxes indicating limitations and restrictions of **less than 2.5 hours in an 8 hour day of sitting, of standing, of walking, reaching overhead or at desk level**, and restrictions from ('no') climbing, balancing, crouching, stooping, crawling, or working extended hours. TN_2APP0018 - 0019. Dr. Lin concluded:

> Mr. Nash was seen by Dr. Tohidi and is now managed by Dr. Helgager who will evaluate him for his disability. His exam is unchanged since my first visit with him. Essentially, with his L severe hip pain, he cannot sit for a prolonged period of time. Anti-inflammatories do not help and narcotics affect cognitive function. He is currently and will be managed by Dr. Helgager for future disability paperwork."

TN_2APP0018 - 0019.

On **3/22/2006** orthopedic surgeon, Dr. Helgager completed a LINA form. His opinions were consistent with the restrictions and limitations placed by Dr. Lin. See TN_2APP0020 - 0021.

At Dr. Lin's recommendation, Mr. Nash underwent a **Functional Capacity Evaluation (FCE)** on **3/30/2006.** That report was previously submitted by Todd with his appeal. TN_2APP0023 - 0038. It confirmed the same clinical condition in which Todd had been since September 2003, with this objective testing by a trained FCE test administrator, that **sitting** is (i.e., continued to be),

> "limited by left hip pain. Needs to frequently change positions. Cannot tolerate upright sitting. Must extend left hip. Estimated tolerance of 15 minutes maximum in good then ≈10 minutes recurrently. He must recline, and then notes increased low back pain."

This is precisely as Todd has consistently reported since becoming disabled end-September 2003. The FCE also found the following limited functionality:

> **Stationary standing** maximum is 15 minutes and then he must sit. The evaluee leans a lot and bears weight mostly on the right when in pain.
>
> **Walking:** Flat surfaces are preferred (maximum is a couple of hundred yards), limited by left hip pain. Inclines are a problem due to shorter step with left leg. Declines tend to jam the left hip joint.
>
> **Stooping:** Able to use golfer's lift or bend forward if he hyperextends the left hip only. He cannot stand erect or bend forward secondary to left hip pain and decreased ROM (mechanical decrease in ROM due to deformity of left hip femoral head).

Squatting: Unable to do at all secondary to left hip pain and decreased Left hip ROM.

These are also precisely as Todd has consistently reported since becoming disabled end-September 2003.

Numerous other activity limitations and limited abilities are discussed on the FCE report itself, *which also objectively test positions and activities and reinforce what Todd has consistently reported to LINA since September 2003.* We refer you to that form.

The evaluator concluded that Todd " demonstrated inadequate workplace tolerance for resumption of his usual and customary job duties (at required level of function) with prolonged sitting in meetings and air travel. Workplace tolerance issues were due to somatic complaints as a result of physical exertion as well as sitting and standing."

> "Based upon FCE results, this client has deficits with: workplace tolerance (when considering usual and customary employment), body mechanics (due to left hip), muscular strength and endurance, ROM, symptom control and loss of worker role identification, all of which contribute to diminished productivity below his usual and customary occupation requirements. Even though strength demands [at his occupation] may be negligible most of the time (unless at a trade show), demand for prolonged sitting and standing appear to be excessive in this gentleman's line of work.
>
> Realistically, in terms of strength, this worker is currently functioning at the "light" physical demand level with push/pull and carrying activities. Lifting is significantly limited as his inability to squat prevents lifts from the floor with proper mechanics. Although able to lift (knuckle to shoulder and shoulder to overhead) in the "light / medium" range, balance due to left LE weight bearing is an issue. On this basis, he appears restricted to no lifts from the ground, and no lifts > 20# in the previously-noted ROM. He is unable to carry objects bilaterally or in the left UE unilaterally. Right carrier should be limited to 15# over 50'. He should avoid squatting and kneeling and bend only on an occasional basis. Also, Mr. Nash needs to **alternate sitting and standing as needed every 15 minutes.**
>
> This client does not appear capable of resuming his usual and customary role in the workforce at present.

On **4/6/2006**, Mr. Nash underwent left hip injection under Flouroscopy. The radiographs demonstrated (consistent with all prior X-rays since 2003) severe degenerative disk disease of the left hip. TN_2APP 0001. Todd then returned to Dr. Helgager on **4/20/2006**, who noted that the procedure was not helpful and that his pain and limited motion remained. TN_2APP 0122. On examination **4/20/2006**, his ROM that day was significantly reduced, at 70° flexion, 15° internal and external rotation, 40° abduction and 20° adduction. Dr. Helgager noted 2 mm shortening of the left leg. Dr. Helgager concluded:

> The Patient states, and I would concur, that he has not had any change in his symptoms since January 2005. The patient has not been helped with injections or physical therapy. He continues to take anti-inflammatory medicines. Patient indicates he is not able to do his job because of his inability to sit for long periods of time at a desk or on an airplane. He has pain and because of the lack of motion is unable to sit. The patient is incapable of flexing his hip beyond 70° at this time. He will continue to utilize over-the-counter or prescription anti-inflammatory meds and occasional Vicodin. Vicodin can cause dizziness, and patient should not drive while taking Vicodin. I would suggest the patient delay his surgery if it is conceivable that he is able to carry out his activities of daily living. . .
>
> I would recommend that this patient undergo a hip replacement or resurfacing procedure in the future. The timing of the surgery is based on the patient's personal situation. Certainly, his hip arthritis makes him a candidate at this time. He is, however, only 42 years of age, and if it is conceivable to delay the surgery for a decade, that would be best."

TN_2APP 0122.

It appears that it would be helpful at this juncture to provide you with some basic information about typical symptoms associated with osteoarthritis, particularly advanced osteoarthritis, of the hip. We found no information in the claim file on this and would have assumed that this would be at least the most basic of inquiries to understand the condition. So that we do not change the actual medical descriptions, we have quoted it here for you, excerpted from Exhibit TN_2APP1330 et seq, attached to this appeal letter. (See http://www.hipsandknees.com/hip/hiparthritis.htm (1 of 2)11/24/2003 3:56:14 AM)

> **SYMPTOMS OF HIP DISEASE**:
>
> **The most prominent symptom of hip arthritis is pain**. Most patients think that their hip is in the region of the buttocks and are surprised to learn that true hip pain is most commonly experienced in the groin. The pain can radiate down the front of the thigh for a few inches as well. Occasionally it goes all the way down the thigh to the knee ("referred pain"). This is because the hip and knee have an overlapping nerve supply. In fact, in some patients with hip disease, knee pain may be the only symptom! Back pain is even more frequently confused with hip pain. Pain in the buttocks, across the low back and down the back of the thigh usually comes from the spine. It usually indicates a pinched nerve in the lower spine. Patients with a pinched nerve will also often have numbness or tingling in the leg. To

complicate matters, some patients with an arthritic hip may also have a pinched nerve from a back disorder. It is important in such cases to determine which problem is causing most of the pain: the hip or the back. If your problem is mainly in your back, you may still be left with most of your pain after going through a hip replacement, and you will not be very happy with the result! If most of your pain is from the hip, a hip replacement may have the added benefit of improving your back condition as well, since the stiffness of an arthritic hip can aggravate a back problem.

Most patients with significant hip disease have a limp and one leg may feel shorter than the other (see true and false leg lengths). Bone-on-bone contact occasionally causes the patient to feel or hear the hip creaking during walking. As the disease progresses, the hip becomes stiff and less movement is possible. This may make it difficult for you to clip your toe nails or to tie your shoe laces, and may also limit your ability to spread your legs. Quite often the first step or two after prolonged sitting may be especially painful. Eventually you may have to "take a break" to ease the pain after walking only short distances. The distance you can walk will gradually decrease until you can only take one or two steps at a time.

Medical information regarding the **treatment of hip arthritis without surgery** is also readily available. We have, again, excerpted this for your information:

1. Should you limit your activities? If you have hip arthritis, the more you walk the more the hip will hurt. In time, running, tennis, golf and eventually even walking may become impossible. You can minimize the pain by simply cutting back on activities which seem to aggravate the hip. Whenever possible, use an elevator (or an escalator) instead of stairs, and avoid long walks that leave you pain. However, "saving the joint" by becoming totally sedentary will not slow down the arthritis. Therefore it is recommended that you remain as active as your pain will comfortably allow. A reported study in the Annals of Internal Medicine, in 1992 suggests that people with hip arthritis who force themselves remain active may do better in the long run than those who "baby" themselves. Also, being totally sedentary leads to a loss of muscle and bone strength. . . . The best all-around exercise for you is swimming. The water relieves the stress on your hip as you "walk" about in the shallow end of the pool. . . .Bicycling (stationary or mobile) is also well tolerated. If you do not have access to an exercise bike or pool, then walk as much as you can tolerate without causing yourself excessive pain.

. . .

> Non-Steroidal Anti-Inflammatory Drugs NSAIDs (Pronounced EN-seds), are a group of drugs which decrease the inflammation (pain and swelling) in arthritic joints. The pain relief from NSAIDs can be quite amazing. Although they are commonly referred to as "arthritis pills", none of them will in any way influence the outcome of the arthritis.
>
> . . .
>
> Allergy to the NSAIDs: This may be manifested as rapid breathing, gasping, wheezing, fainting, hives, itching, skin rash, rapid heart beat, or sudden puffiness of the eyelids. Allergy is exceedingly rare. It occurs sometimes in people who are truly allergic to aspirin. If you have these symptoms and you do not have someone to drive you to the hospital, call an ambulance and get to the hospital as soon as you can, since the allergic reaction could be severe and need urgent medical treatment.
>
> . . .
>
> Pain Medications: Eventually NSAIDs will not give you adequate relief. If for some reason you are not able to undergo hip surgery by that time, then your only recourse is to take pain medications, starting with over-the-counter medications such as Tylenol, and progressing to stronger prescription medications from your doctor as necessary.

Again, Mr. Nash's occupation is sedentary, as confirmed by LINA throughout the claim. Only after the surveillance footage did the claims department at LINA attempt to re-classify his entire occupation as he usually performed and as performed in the general economy as an occupation within the "light" strength category. Mr. Ey apparently contributed to LINA's efforts in that respect by pointing to the occasional travel involved in the occupation —travel in which substantial periods of prolonged sitting on the plane during long flights is involved. Mr. Ey pointed to walking in the airport and carrying bags (which he assumed). Mr. Ey admitted that even the old, 1991 "DOT categorizes [Todd's] occupation at the **sedentary exertional level**. Sedentary work is that which requires occasional lifting to 10 pounds and which is performed, **primarily, while seated**." TN_2APP 1066 - TN_2APP 1067.

Mr. Nash addressed the occupational information through his appeal at Exhibits 17 - 23 of his first appeal (TN_2APP 0373 - 0420). Todd included detailed information from the DOL's current occupational assessment data bank, **O*NET** (TN_2APP 0377) and the Occupational Outlook Handbook for 2006/07 (TN_2APP 0398). Even Mr. Ey's comments, in his attempt to change the occupation from a sedentary occupation to a "light" occupation ignored the most basic of the then-long-standing definitions used by the old DOT.

For instance, the last version of the former D.O.T. (1991 revised) contains five strength categories, the lowest level of which are the "sedentary" or "light" categories. These refer to the "Physical Demands - Strength Rating (Strength) description in the DOT. That section states:

"The Physical Demands Strength Rating reflects the **estimated overall strength requirement of the job**, expressed in terms of the letter corresponding to the particular strength rating. It represents the strength requirements which are considered to be important for average, successful work performance.

The strength rating is expressed by one of five terms: Sedentary, Light, Medium, Heavy, and Very Heavy. In order to determine the overall rating, an evaluation is made of the worker's involvement in the following activities:

a. Standing, Walking, Sitting

Standing - Remaining on one's feet in an upright position at a work station with-out moving about.
Walking - Moving about on foot.
Sitting - Remaining in a seated position.

b. Lifting, Carrying, Pushing, Pulling

Lifting - Raising or lowering an object from one level to another (includes upward pulling).
Carrying - Transporting an object, usually holding it in the hands or arms, or on the shoulder.
Pushing - Exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking, and treadle actions).
Pulling - Exerting force upon an object so that the object moves toward the force (includes jerking).

Lifting, pushing, and pulling are evaluated in terms of both intensity and duration. Consideration is given to the weight handled, position of the worker's body, and the aid given by helpers or mechanical equipment. Carrying most often is evaluated in terms of duration, weight carried, and distance carried.

Estimating the Strength factor rating for an occupation requires the exercise of care on the part of occupational analysts in evaluating the force and physical effort a worker must exert. For instance, if the worker is in a crouching position, it may be much more difficult to push an object than if pushed at waist height. Also, if the worker is required to lift and carry continuously or push and pull objects over long distances, the worker may exert as much physical effort as is required to similarly move objects twice as heavy, but less frequently and/or over shorter distances.

The strength categories refer to the words "*occasionally*" and "*frequently*" in the context of a term of art of the D.O.T. as opposed to the customary use of those terms by claimants, physicians and other lay individuals in the general vernacular. The D.O.T. (1991, revised) defines:

> "*Occasionally*" as activity or condition that exists up to 1/3 of the time (--i.e., 2.66 hour in an 8-hr day)
>
> "*Frequently*" as activity or condition exists from 1/3 to 2/3 of the time (i.e., up to 5.3 hrs in an 8-hr. day)

The above 'occasional' and 'frequent' terms are used in the D.O.T.'s definitions of its several strength categories, the first two of which are:

> **S-Sedentary Work** - Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull, or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.
>
> **L-Light Work** - Exerting up to 20 pounds of force *occasionally*, and/or up to 10 pounds of force *frequently*, and/or a negligible amount of force constantly (Constantly: activity or condition exists 2/3 or more of the time) to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible. [25]

D.O.T. (Revised, 1991) Vol. II at pp. 1012-1013. (TN_2APP 1399-1400).

Mr. Nash previously demonstrated that his occupation is unquestionably an occupation within the sedentary physical demands strength category, as Mr. Ey confirmed. But the physical demands category is only one of a number of occupational features, and moreover, the physical demands category includes bending, stooping, pushing, pulling, lifting including from the floor, climbing, etc., and all of the cognitive requirements of the occupation, which in Todd's level, involved a high level of cognition, which could not be adequately and accurately performed when affected or influenced by the presence of narcotic pain drugs.

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[25] We also provide you with the appendices and tables of the 1991 DOT revised, which reflects the various components of any DOT occupational description. TN_2APP1361 et seq.

Allow us to explain some basics of the former U.S. Department of Labor's (DOL) Dictionary of Occupational Titles (DOT), Fourth Edition, 1991 Revised (which has since been replaced by O*NET). It reflected a "general" description of a Job Titles that had been compiled from numerous job analyses (of the same job title) conducted in the U.S. labor market as they had been found to occur as of 1991. The old DOT job description consisted of two sections:

1) the Narrative Description of the job title and,
2) the Worker Qualifications Profile (**WQP**) which defines the "worker characteristics" that are required to perform the job.

The latter —the Worker Qualifications Profile (**WQP**)— is made up of **six** (6) **General Factor** categories with varying numbers of sub-factors under each category. They are:

(1) Aptitudes (with 11 sub-factors);
(2) General Educational Demands (GED) (3 subfactors);

(3) Physical Demands (there are 20 sub-factors)
The 20 sub-factors include, but are not limited to: **Strength; Climbing; Balancing; Stooping; Kneeling; Crouching; Crawling; Reaching; Handling; Fingering; Feeling**

The DOT ratings with regard to the **Strength** sub-factor include:

Sedentary (S) – exerting 10 pounds of force *occasionally* and/or a negligible amount of force *frequently* to lift, carry, push, pull, or otherwise move objects, including the human body.

Light (L) - exerting up to 20 pounds of force *occasionally*, and/or up to 10 pounds of force *frequently*, and/or a negligible amount of force *constantly* to move objects.

DOT ratings with regard to all other Physical Demands sub-factors:

N	Not Present	Activity or condition does not exist
O	Occasionally	Activity or condition exists up to 1/3 of the time
F	Frequently	Activity or condition exists from 1/3 to 2/3 of the time
C	Constantly	Activity or condition exists 2/3 or more of the time

(4) Environmental Conditions (and its 14 sub-factors)

(5) Temperaments (and its 11 sub-factors)
This fifth factor (*the adaptability requirements made on the worker by specific types of jobs*) is significant for requiring three of the 11 sub-factors —**Judgments, People**, and **Stress.** These 3 Temperaments, considered to be important in relation to the kinds of adjustments that the employee must make to successfully perform the material duties of his occupation,

are: **J** – Making **JUDGMENTS** and decisions; **P** – Dealing with **PEOPLE**; **S** – Performing effectively under **STRESS**.

(6) Specific Vocational Preparation (SVP)

As you can see, even under the old D.O.T., the Physical Demands - strength category is the third WQP General Factor. Each **WQP General Factor** category has a **distinct rating system** as specified in the *Revised Handbook for Analyzing Jobs* (U.S. Department of Labor Employment and Training Administration, 1991), as well as additional narrative factor descriptions that are not included in the *DOT* job description, but that were very important when performing an analysis of an occupation. With respect to Mr. Nash, it can be assumed that he would meet WQP factor 1 (Aptitudes), 2 (General Educational Demands) and 6 (Specific Vocational Preparations) since he had and was qualified for that job.

Occupations have evolved and changed since 1991, just as technology has drastically changed since that time.

In contrast to the old DOT, an **O*NET job description analyzes 483 descriptors** for each occupation. They are rated in one - three Scales (Level, Importance and Frequency) and are given a **Value** from 0 – 100.[26] The details of an O*NET occupational description are clustered into eight categories (Knowledge; Skills; Abilities; Work activities; Work contents; Tasks; Interests; Work Values). Mr. Nash has already presented the updated and more comprehensive O*NET occupational descriptors with his first appeal. It is also obvious from his first appeal, as admitted by LINA, that his occupation is predominately long periods of sitting all day, and even his travel requirements involve long periods of sitting on planes. These all fit within the definition of "sedentary" even without consideration of other bending, stooping, lifting from floor level, etc., that many such occupations also entail.

In any event, Mr. Nash does not have the capability to perform all of the material duties of any sedentary or light occupation due to his sitting, standing and walking impairments, limitations and restrictions, need for longer and longer periods of rest over the day as he attempts these positions or activities to points that cause substantial pain, as well as due to his marked motion impairments, and his lifting restrictions and limitations.

It is clear that significant levels of pain produced by prolonged periods of sitting all day, which Todd's occupation (or frankly any other sedentary occupation) requires, or even those occupations that require substantial day-long standing, walking and sitting with occasional lifting of up to 20 pounds 1/3 of each day, are activities and positions that Todd *cannot tolerate* and/ or has been medically restricted from, and has continually been unable to tolerate since September 2003 due to his advanced hip disease. He is unable to concentrate and engage in any advanced level of judgment and analysis and thinking when in such pain. The only way to reduce the pain to a tolerable level is to cease the activity and recline and rest for significant periods and/or begin taking regular daily doses of narcotic pain relievers such as Vicodin. This is not medically advisable and would cause prescription narcotic dependency, and would render him unable to perform the cognitive requirements of the occupation.

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[26] 1. Level: What "level" of this activity in needed to perform this job; 2. Importance: How "important" is this activity to performance on this job; 3. Frequency: How "often" is this activity performed on this job. **Value:100 = Always; 66 = Often; 33 = Sometimes; 0 = Almost Never**

Instead of reinstating his claim, LINA instead issued another denial letter, dated 7/10/2006 (but postmarked 7/13/2006 and not received by Mr. Nash until 7/16/2006). TN_2APP1061 - 1063 We will refer to that as the "July 2006 Denial Letter." It is addressed further below:

July 2006 Denial Letter. It states:

> . . . you have been off work since September 29, 2003 due to osteoarthritis of the hip. As stated to you in our letter of June 20,2006, we conducted a medical review. As part of his review, our medical director reviewed all the medical information contained in your claim file.
>
> After review of the entirety of the medical information in your file, our medical director noted that most of the medical information provided were several years old and prior to when your Disability benefits ended.
>
> Our medical director noted that you saw various physicians from December 2005 to April 2006 and also underwent a FCE in March 2006. However **this information is several weeks to several months after your Disability benefits ended and does not provide evidence of continuous Disability as of November 30,2005**, when your benefits ended.
>
> Our medical director also stated that although surgery was recommended 6 weeks after your benefits ended, the medical records in file do not support severity of any condition as of November 30,2005 that would support limitations and/or restrictions precluding you from performing your occupation.
>
> Summary . . . "While the documentation on file described your conditions, it does not provide **clinical findings** that would support the **severity of your condition and functional deficits** that would preclude you from performing your occupation as of November 30, 2005, when your [LTD] benefits ended. . ."

First, the "medical director" to which LINA refers as having reviewed the records prior to the first denial is a nurse. Therefore, this statement in the second denial letter is misleading at best.

We note from the claim file that the nurse recommended the claim personnel request updated ROM data, but the claim personnel did not follow up with any specific requests for that to Todd or his physicians. [27]

If there was a physician review, in particular board certified hip specialist, Mr. Nash was certainly not given any understanding of who that was, when the review occurred, his or her credentials, and the actual basis of any such review and assessment.

With respect to the "review" by your "medical director" after Mr. Todd's appeal, the July 2006 denial letter did not identify his qualifications in the specialty of orthopedic surgery and in particular, of hip disease. There is only cryptic non-analytical conclusory comments made by LINA's Dr. Taylor. Without assessment or discussion of the advanced nature of Mr. Nash's disease condition or the associated symptoms historically and then to date, Dr. Taylor, D.O. asserted —incredibly— that the medical records submitted with the appeal are too remote in time –too old– to be relevant and assist in the understanding of Todd's continued disability or to qualify as sufficient 'proof' of continuing disability. To the contrary, when viewing the record as a whole, the nature and level of his disease and the nature and level of his associated limitations, restrictions placed by his physicians and his disabling symptoms (and with what associated positions or activities) are abundantly clear.

The spin on the timing of events as articulated by Dr. Taylor is very troubling. He refers to the last date through which benefits were paid as the 'denial' date. (Dr. Taylor asserted that "new medical includes an exam by PCP 3 weeks after denial.") The record itself proves this false, as the 'review' continued well into December. Moreover, benefits for each month *are not paid until the end of the month*. Therefore, the December 13/14, 2005 letter was the date by which LINA made its determination, and was the indication that no end-of-the-month benefits payment would be received on the next payment due date at the month's end, 12/31/05. The PCP examination on 12/19/2005 was less than one week after the date on the denial letter. It also ignores the fact that Dr. Tohidi submitted a PAA form in October 2005 attesting in writing to the continued disabling condition of Mr. Nash. Dr. Taylor criticizes that "no notes are provided from physical, PT, or anywhere else that gives info of deficits on or around denial date." That too is false. Moreover, if there was something LINA allegedly needed to confirm continued disability, such as ROM values, LINA had a duty to request it specifically or to have ordered an examination to get those degrees of limitation itself before it terminated the claim. LINA did not ask him to undergo updated ROM testing and submit those measurements. There was no meaningful communication of this alleged needed ROM tests, without which LINA allegedly could not confirm his continued disability. Given the nature of his disease, and his history, and the medical records in existence before the denial, that 'rationale' is absurd. With this advanced severe level of condition, the lack of a 'measurement' of internal or external rotation by the last benefits payment (November 30, 2005) should not suggest, in a *degenerative disease* — that the ranges of motion would be expected to improve. Nor does it change the fact he experiences significant pain after short periods of sitting or standing due to the bone on bone grinding and friction.

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[27]For instance, LINA's claims department did request of Dr. Tohidi the following on 2/4/2004 and 3/4/04: "Please provide copies of office notes, laboratory results and any other test results from 09/01/03 to Present. These records may include any tests, office notes, and treatment plans that are within the patient's file. I understand that there may be a fee for this service, please be sure to provide me with your tax identification number." E.g., TN_2APP0934. The medical records were provided, and the claim granted. 3/26/2004. TN_2APP0923 - 0925. According to the claim file, the nurse reviewed the file again ion 11/2/04 and claimed to have "no current ROM, pain scale, or R/L's in file" although they had a PAA completed 11/03. TN_2APP 0671. Since then, LINA obtained by telephone information they were requesting in late November 2003 (TN_2APP 1015), and simply asked (in December 2004: TN_2APP0873) Dr. Tohidi to send his progress notes, including diagnostic test and lab results, from **01/04 to the present**. And to complete another PAA form. Dr. Tohidi provided the information. Yet in the fall of 2005, the only thing requested of Mr. Nash or Dr. Tohidi was that he complete another PAA form, which he did. Finally, while the nurse notes on 12/6/2005 claim there was "no current med. In the file" "no ROM values, no current X-rays", and that LINA wanted Dr. Tohidi's office notes, at no time did LINA's nurse or "case manager" (CM) actually advise Todd of what tests or exams they were seeking, again, no one at LINA advised Mr. Nash that is what they needed from his physicians. Mr. Nash addressed this to LINA. TN_2APP 1191 -1192

Such a myopic focus on the date of "November 30, 2005" last monthly benefits payment for the month of November 2005, and contention as stated by LINA in the July 2006 letter • disregards the degenerative and progressive nature of Todd's advanced osteoarthritic condition, • disregards the comprehensive appeal of May and June 2006, • disregards his marked symptoms, • disregards the bone-on-bone pain-producing grinding/friction, • overlooks the recommendations of his inability to sit for prolonged periods without long periods of rest between to lessen the pain, or the continued levels of intolerable pain and resulting inability to focus or concentrate or do anything other than try to alleviate the pain, • overlooks or disregards the recommendations and restrictions and limitations placed by his treating orthopedists who have consistently and continuously reported that he is disabled from performing his regular occupation or, frankly, any gainful occupation.

LINA has pointed to nothing indicating the above has improved, or that he has suddenly grown new cartilage in his hip joint, or that the deformed head of the femur has miraculously normalized etc., or that the osteophytes have disappeared, especially given the contemporaneous evidence of ongoing orthopedic difficulty and continued severity of hip condition in assessments in late 2005/beginning of 2006, and subsequently, to date.

As we pointed out above, Todd did address some of his concerns about the July 2006 denial of his appeal in letters to LINA. Those materials should be considered included with his 'appeal' materials. They are at TN_2APP 1051 - 1058 and 1191 - 1192.

Moreover, Todd's symptoms have been manageable ONLY BECAUSE HE IS AVOIDING the very positions, postures and activities which became disabling to him because of the severely advanced level of his osteoarthritis. This claim does not involve a man who suffered an acute injury, for instance, such as a spiral break of the leg which heals over time and slowly allows him to rehabilitate, undergo therapy, and increase his activity and return to work. Todd has advanced osteoarthritis of the hip with obliteration of the super lateral joint space, complete loss of all cushioning articular cartilaginous surfaces and a resulting bare bone grinding against bare bone in the hip with deformity of the head of the left femur. This is also the presence of osteophyte and cyst.

Continuing to deny this claim under the excuse that his medical records, *which have been consistently severe with consistently limited physical and positional abilities from August 2003 to date*, don't have a ROM test by end November 2005 (which was not requested by LINA) is disingenuous and pretextual. It is unsupported factually and by medical history. Numerous courts have addressed such contentions. We direct your attention to only a couple from this circuit. *Silver v. Executive Car Leasing Long Term Disab. Plan*, 457 F.3d 982 (9th cir. 2006), 466 F.3d 727 (9th Cir. 2006) as amended.; *Jebian v. Hewlett-Packard Co. Emple. Ben. Org. Income Prot Plan*, 349 F.3d 1098 (9th Cir. 2003) en banc, cert denied, *Hewlett-Packard Co. Emple. Ben. Org. Income Prot. Plan v. Jebian*, 125 S. Ct. 2956, 162 L. Ed. 2d 887 (2005)[28];

The records that LINA had at the time of its July 2006 letter contain ample evidence that Todd's hip disease and related impairments did not lessen nor dissipate. Moreover, LINA has additional evidence from Dr. Tohidi most recently confirmed, as have Todd's other physicians throughout 2005 and 2006, that his severe disease and his disability has at all times continued on and after the "November 30, 2005" date to which LINA incredulously points. It is just as incredulous for LINA to argue that a man in Todd's advanced osteoarthritic state, with respect to the left hip, though totally disabled by his interacting impairments from prolonged sitting, standing, stooping/bending/crouching lifting from ground level, inability to take NSAIDS for any pain relief, and rely completely on avoidance and abstention of the activities that produce his severe levels of intractable pain or the use of mentation-altering narcotic pain drugs, would suddenly experience a significant resolution of his condition in November/December 2005 and then return to that condition by his next followup examination(s) and remain so thereafter. While he may not have experienced an additional acute further injury to the left hip during this short month or two in late 2005, the subsequent records clearly document his continuing disability due to precisely the same degenerative advanced osteoarthritic condition makes LINA's July 2006 position all the more untenable.

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[28]In *Jebian*, the "VPA" had denied the claim 8/3/98. Jebian appealed it in November 1998. The court stated,

> "Dr. Landes, ..began treating Jebian in September 1998 after Jebian moved to a new area stated in his November 1998 letter in support of Jebian's appeal that patients with his condition "are permanently precluded from activities requiring . . . prolonged sitting or prolonged standing," and that "his current physical exam findings confirm the information in the records and support his claim of permanent disability, limiting him to sedentary work."
>
> VPA argues that Jebian's extensive medical evidence does not pertain to the relevant moment, which is the end of the temporary disability benefit period, March 3, 1998. A trier of fact, reviewing the entire record submitted to VPA, could conclude otherwise. For example, although VPA rejected records from 1995 as "immaterial" to Jebian's disability in March 1998, in fact those records are pertinent, although certainly not determinative. They both trace the history of Jebian's back injury and indicate that it is capable of causing total disability. Jebian's treating physician, Dr. Lu, certified on January 30, 1998, that Jebian remained severely functionally limited due to his back injury. Dr. Lu's opinion was based on a June 1997 office visit and over two years' experience in treating Jebian's back ailment. Finally, Dr. Landes, contrary to the district court's understanding, did examine Jebian himself, in September 1998 [i.e., after VPA's 8/3/98 denial], and based his October 1998 letter in part on that examination.
>
> A trier of fact, reviewing the evidence ...could infer that functional limitations confirmed by treating physicians in June 1997, May 1998, and September 1998, more likely than not existed in March 1998 as well, rather than disappearing before March 1998 and reappearing thereafter." Jebian at 1109-1110.

We also take note of the July 2006 letter's contention that "surgery was recommended" only after "benefits" ended. This is a mischaracterization of the medical records. Those records from August 2003 to date all discuss the fact that his left hip disease is advanced and severe and that one of the options is that of a total hip replacement and its optimal timing based on innumerable considerations including life of a prosthesis and future re-do. All of the medical specialists who have treated and followed him are also in agreement with him that as long as he can manage the pain levels through his greatly reduced activities and positional requirements which produce his high pain levels, that he should hold off on the replacement until such time as he cannot control pain through the activity modification. All specialists have advised him of the limited life span of a hip replacement, and given his young age, the necessity that once it is replaced, it will need successive replacements/redo's in the future, which have additional complications and limitations. His pre-disability medical records from early 1998 to date discuss the future need for surgery:

- 4/27/98 when symptoms first began appearing state, for example, "he will probably need a joint replacement at sometime in the next 5-10 years but he should try to put it off as long as possible." TN_2APP 0039.

- 8/8/03, "He is interested in learning of any other measures to control his pain while he is adding more years prior to a hip replacement. . . . In my opinion the treatment options include intermittent injections, in my opinion versus a total hip replacement. A hip fusion in this patient will be very debilitating as the present problem is inadequate flexion of the hip and problems with sitting." TN_2APP0079 - TN_2APP 0080.

- 8/14/03, Dr. Tohidi noted, among other, " . . . It will be determined whether or not he can continue with conservative management or surgical intervention can be implemented at that time." TN_2APP 0077.

- 9/15/03, Dr. Tohidi again discussed the topic of proper timing of a hip replacement. ". . . The treatment options were discussed with him. At this time it is obvious that the Injection did not provide any long-term improvement and therefore, **symptomatic treatment and activity modification** versus a hip replacement would be the options of treatment. Presently, he does not wish to proceed with a total joint considering his age. He will eventually need such a procedure, but I would recommend that he wait until his symptoms are more severe and more disabling." TN_2APP 0077.

- 9/26/03, Dr. Tohidi: ". . . His **pain is essentially intolerable when he is confined to sitting for a prolong period**, i.e., when he travels or when he is in meetings where he has to sit confined to a space for some time. He has reached the point where he is **unable to withstand the extent of the pain and remain functional at his present job description**. [¶] The treatment of the hip condition, i.e., the osteoarthritis, will be a total hip replacement, but since he is capable of carrying out his dally living activities, I recommend that his job be modified to eliminate frequent travel and also frequent meetings so that he can remain functional. If that will not be a possible for him, then I would recommend he be considered disabled. [¶] I would like to follow him periodically and, obviously, if his hip pain continues to progress, at some point in the future he will be a candidate for total hip replacement. He understands the long-term plan." TN_2APP 0076.

- 1/14/04, Dr. Tohidi. . . . "The eventual treatment for Mr. Nash, as I had mentioned previously, is a total hip replacement, which has a finite life and obviously, because of his age, that treatment has been reserved to be applied in the future. I would therefore recommend that Mr. Nash be followed periodically..." TN_2APP 0074 - 0075
- 1/4/2006, the patient saw Dr. Padilla on a single occasion, since Dr. Tohidi was in Georgia, but does not appear to have had or reviewed Mr. Nash's medical records, and thus indicated that one consideration instead of a conventional total hip would be surface replacing hip arthoplasty (TN_2APP 0118 - 0119).
- 2/9/2006. Dr. Helgager, orthopedic surgeon. "I would not recommend total hip replacement at this time. . . . If patient comes to a total hip replacement surgery, then the outlook for this surgery is excellent although, he is quite young, and we certainly could not guarantee that he would not require revision hip surgery. I discussed with him use of metal on metal because of his age or possibly ceramic on ceramic if he comes to hip replacement surgery. In addition, I did discuss with him that there are some new designs for hip resurfacing that possibly would offer the patient another solution. I will see the patient in a year with x-rays." TN_2APP 0120 - 0121
- 2/13/2006. Dr. Stacey Lin: "The plan, however, is to continue with the current care considering his age. They are trying to prevent multiple revisions and the request is to delay any sort of surgical intervention at this time"
- 4/20/2006. Dr. Helgager: He does not want to proceed with hip replacement or resurfacing at this time.. . . I would suggest the patient delay his surgery if it is conceivable that he is able to carry out his activities of daily living. . . . I would recommend that this patient undergo a hip replacement or resurfacing procedure in the future. The timing of the surgery is based on the patient's personal situation. Certainly, his hip arthritis makes him a candidate at this time. He is, however, only 42 years of age, and if it is conceivable to delay the surgery for a decade, that would be best." TN_2APP 0122

The above quoted short excerpts are taken from the entirety of the visit notes or reports. However, they make it clear that there is and has been an ongoing assessment as to the future expectation that Todd will undergo a total hip, and until the appropriate time is determined, which appears to be within the next ten years, the only available successful pain management is avoidance of the positions and activities that cause marked and intolerable levels of pain.

In addition, we provide you with general medical discussions of this issue (WHEN SHOULD YOU HAVE HIP REPLACEMENT SURGERY? -- Arthritis Hip Surgery Info - Total Hip Replacement):

> If your symptoms are mainly from an arthritic hip, and you are physically fit enough to undergo surgery, when should you consider having your hip replaced? Hip arthritis is not a life-threatening condition: the procedure is "elective." There are possible complications associated with hip replacement surgery (see Complications of Hip Replacement Surgery) .... The decision to have the operation is a highly personal matter, and only you can make that decision.
>
> . . .
>
> Here are some facts to help you make your decision:
>
> 1. Once you have hip arthritis it will never get better. It won't even stay the same. It will generally progress as time goes by. There are no exercises, diets, vitamins, or minerals (except, perhaps, chondroitin sulfate) which will make any difference.
>
> ...
>
> 2. The rate of further deterioration varies greatly from person to person. The pain may become unbearable within six months for one person, yet drag on at a tolerable level for several years in another person who has the same degree of arthritis.

LINA's argument that while Todd submitted proofs from September 2003 to mid October 2005, and proofs of continuing severity and disability in mid December 2005 to date, there was allegedly no medical document on 11/30/2005 "when benefits ended" that stated he was disabled, is totally arbitrary. Also, there was no request for any *specific* proof—no request for ROM studies or X-rays for example.

	DOCUMENTED ∘∘∘ Severe Osteoarthritis LT hip ∘∘∘ ∘totally Disabled∘	Allegedly not Disab	DOCUMENTED ∘∘∘ Severe Osteoarthritis LT hip ∘ ∘∘totally disabled∘∘∘
I.e.,:	9/03 ➩ 2004 ➩ 2005 ➩	Dec. 1-14	12/19/05 ➩ 1/06 ➩ 4/06 ➩ 10/06

Benefits payments for each mo. at month's end

As to LINA's contention, to support LINA's approach, the policy as written would have required LINA to advise Mr. Nash each day, or each week, or each month that it needed new medical proof of disability and precisely what it wanted: a new examination, a new X-ray, horizontal or standing; new hip ROM studies to see how much further deterioration there had been since the last. Here, the inference LINA makes is that while it requests PAA forms to be completed, it will reject them arbitrarily if something else it wants, but has not requested is not listed on them.

The inference is also that new forms would be needed, and new examination or X-ray or ROM study by the end of each month to qualify for benefits payments that month. The Policy does not require or even support this. If LINA approached disability claims such as this one that involve an already disabled patient with a degenerative and progressive condition, it would promote excessive, medically unnecessary care. And if it needed repeat X-rays within a certain time frequency, even though the patient's symptoms and limitations were remaining at the same disabling level, then it needed to tell Todd and his physicians this, or order the X-ray itself as part of its examination process prior to terminating the claim. This Circuit requires meaningful communications from insurers (*.Booton v. Lockheed Med. Benefit Plan*, 110 F.3d 1461, 1463-64 (9th Cir. 1997).

Even if "November 30, 2005" was some magic date as to the next month's continuing disability, the policy itself would have given Todd 30 days from a written notification of the need for an examination. However, Todd had already undergone an updated follow up and had received a renewed prescription for treatment of his pain (of Vicodin): by Dr. Lin in mid December 2005. And he obtained updated information immediately thereafter in 2006. California insurance law gives him a statutory right by compulsory policy provisions to an additional 90 days to submit proofs of continuing disability; ERISA grants 180 days from a denial to perfect his claim; and LINA invited additional ongoing information through its December 13, 2005 and July 10, 2006 letters to submit his written proofs. (E.g., to submit "- Copies of any other **diagnostic test results** which document the severity of your condition to the extent that you are unable to perform the duties of your occupation or any occupation."). Again, if it was a medical examination on November 30, 2005 or December 13, 2005, *then LINA needed to advise Todd of that fact*.[29] LINA did not do so until the December 13 2005 termination itself. Therefore, Todd immediately sought to obtain all of the information LINA appeared to claim it needed.

The concerning approach of LINA is also reflected in the denial letter. In it's request for information, it states for example that he must

> "include copies of any recent test results performed (in the last 6 months). In the absence of such report *we shall assume that these revealed normal findings and unimpaired function*" [!] (emphasis added).

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[29] *Booton*, 110 F.3d at 1463-64 (to deny the claim . . . without obtaining relevant information is an abuse of discretion. See Kunin v. Benefit Trust Life Ins. Co., 910 F.2d 534, 538 (9th Cir. 1990)(burden is on plan to obtain adequate information to make decision); cf. Halpin v. W.W. Grainger, Inc., 962 F.2d 685, 691 (7th Cir. 1992) (an ERISA plan cannot rely on a lack of information to support its denial of benefits when it fails to inform the beneficiary about the missing information so that the beneficiary can provide it." . . . Quoting 1967's Cool Hand Luke: "What we got here," said Strother Martin, "is a failure to communicate." n9 This is an all-too-common occurrence when ERISA-covered health benefit plans deny claims.).

Such threatened "assumption" given this man's clearly and well documented history is absurd. Moreover, the denial letter itself did not even advise him of the specific tests that LINA claimed to need: ROM tests specifically, or X-ray updates, specifically, and why, including why specifically they could refute Todd's ongoing pain when engaging in too much sitting beyond his limited tolerance, due to the bone on bone contact and other disease pathology present in the hip.

That notwithstanding, the proof due date for continuing loss is simply a due date for the submission of the written proof of continuing disability.

The policy does not require Todd to undergo an updated medical examination by his hip specialist or PCP every week or every other week, or every month, or every other month particularly when he has a permanent condition which is degenerative in nature. It does not require the written proofs forms (the PAA forms and Disability Questionnaires) to be completed every week, or every other week, or every month, or every other month. Nor was the policy administered in that manner from the beginning of his disability.

Moreover, his condition is periodically re-evaluated through follow up visits at least once a year by his PCP, and approximately every six to twelve months by his hip specialist, unless he experiences a sudden and noticeable deterioration that might implicate the need for immediate reconsideration of a total hip. That deterioration has not occurred.

Dr. Tohidi has explained that it was and is his recommendation to Mr. Nash that he (Mr. Nash) be seen annually for purposes to evaluating the extent of deterioration and timing of a total hip. We have quoted Dr. Tohidi below. Todd has followed the sound medical advice of his treating providers.

As it was, we reiterate, Mr. Nash saw Dr. Lin in December 2005, only 19 days after the 'last' benefits payment was being forwarded by LINA –although unknown to Todd until he was informed by telephone and fax on December 13, 2005 that his claim was terminated. This occurred immediately before the year-end holiday and new year. He diligently sought additional information for LINA despite the usual medical visit scheduling difficulties which patients face through their health plans, and underwent updated horizontal (not standing) X-rays on January 4, 2006 plus examination by Dr. Padilla. Within one month, he followed up with a new orthopedist who was to become one of his regular treating orthopedists, Dr. Helgager, who examined him on February 9, 2006. Mr. Nash submitted updated PAA forms from both Drs. Lin and Helgager in March 2006 (both of whom concur with all past assessments of Dr. Tohidi), underwent a flouroscopy procedure in April 2006 which is entirely consistent with and reaffirms the continued presence of his severe disease which produces his impairments and restrictions and pain. We have already addressed the clear medical information documenting this man's disability from his severe condition. He has since seen Dr. Tohidi again because Dr. Tohidi is so familiar with his condition and treatment and medical history.

We have copied the content of Dr. Tohidi's opinions as stated in a recent letter of **10/23/2006**:

> "I am forwarding this letter on behalf of Mr. Todd Nash whom I have seen and treated since 2003 for severe osteoarthritis of the left hip. I have seen him at least six (6) times during this period, to date, and am obviously very familiar with his testing, his clinical presentation, and significantly limiting symptomatology. He has followed my medical recommendations and seen me at the intervals I have recommended. The condition of his hip was advanced at the time of initial evaluation. I provided him with information regarding various treatments including pain management, activity modification, hip replacement, their types, complications, risks, limitations, and prosthetic life expectancy. For the time being, because of his age, he chose to live with this condition and attempt to manage his symptomatology and rather marked limitations by significant activity restrictions and limitations. By "activity," I am including limitations in exertional and nonexertional "activity" such as his inability to sustain prolonged positional sitting or standing. At some point in his future, he will undoubtedly need to revisit the appropriate future timing of a total hip replacement, but for the time being, I concur with his decision.
>
> Mr. Nash is allergic to aspirin. I have prescribed him Vicodin 5/500 to relieve pain. I have advised him that the side affects of this narcotic pain medication include probable reduction of cognitive ability and ability to concentrate. I have advised him that he should not operate an automobile while taking this medication.
>
> It is my medical opinion that appropriate care and treatment for Mr. Nash has been and continues to be to manage his illness by activity modification and pain management while postponing total hip replacement for as long as Mr. Nash can tolerate his condition. This medical recommendation comes after multiple examinations including x-rays, a cortisone injection that has shown to provide neither increased capacity nor sustainable reduction in pain, and the exclusion of non-steroidal anti-inflammatories due to Mr, Nash's aspirin allergy.
>
> Due to the progressive degenerative nature of Mr. Nash's illness, providing the appropriate level of care requires that I, or other qualified physician, see him no more that once per year or more frequently if, in Mr. Nash's own opinion, his personal status changes such that he desires to pursue total hip replacement surgery. Prior to today, October 23,2006, I last saw Mr. Nash in January 2005. The severity of his condition over this period remains the same to moderately worse.

Mr. Nash has a significant functional disability due to existing marked stiffness and pain with activity. This is noticeable in my examinations of him, in his movement, in the consistency of his reports that I take during each history and follow up visit, and in the pain behavior that I personally witness. The symptoms and significant limitations of Mr. Nash are those that I would expect given his hip illness and they are fully consistent with other patients I see with a similar level of hip disease. Based on my expertise in this specialty, it is my medical opinion that Mr. Nash has demonstrated no malingering during my examinations and interviews of him, and that his complaints, symptoms and signs, are fully consistent with the level of disease he has and with other patients I see who are in the same condition and at the same stage of their disease

In August 2003, I measured Mr. Nash's range of motion in his left hip as being 0 degrees of external rotation, about 30 degrees of internal rotation, 25 dg of abduction, 15 degrees of adduction, and 50 degrees of flexion. (Estimates of average normal limits of hip joint motion are 45 degrees of external rotation, 45 degrees of internal rotation, 45 degrees of abduction, 30 degrees of adduction, and 120 degrees of flexion.) These measurements objectively show that Mr. Nash is incapable of flexing his left hip into an upright sitting position. This inability to sit upright remains true today.

I have reviewed the medical records provided by Dr. Stacey Lin, dated December 20, 2005, Dr. Patrick Padilla dated January 04,2006 and by Dr. James Helgager, dated February 9, 2006 and April 20,2006, including x-rays taken on January 4,2006. The January 4,2006 x-rays, and the observations reported in Dr. Lin's, Dr. Padilla's and Dr. Helgager's notes generally concur with my assessment of Mr. Nash and provide further evidence that Mr. Nash's illness has progressed, as expected, in a degenerative way and shows no sign of improvement since Mr.Nash's office visit with me in January 2005.

Due to the progressive degenerative nature of Mr. Nash's illness, the severity of his illness has not and could not have improved in the continuous period from September 2003 to January 2006 and beyond. Additionally, the resulting limitations and restrictions associated with his illness have not been and could not have been lifted in the continuous period from September 2003 to January 2006 and beyond and certainly not on November 30, 2005 or on December 13, 2005. This will remain true until such time as Mr. Nash has undergone total hip replacement and rehabilitated. Of course, this is not a guarantee that even then he will not continue to have limitations and his activities be restricted. It may also be associated with discomfort with prolonged positions and activities. However, it is premature to address that at present. I have added the underlining in the above passage to emphasize my professional medical opinion because I understand from reading the letter from CIGNA dated July 10,2006 to Mr. Nash that CIGNA has apparently reasoned that since Mr. Nash was not seen during a specific period that he somehow was not disabled or limited and restricted at that time. This rationale is medically preposterous.

The progressive degenerative nature of Mr. Nash's illness combined with the evaluations of Dr. Lin, Dr. Padilla, Dr. Helgager, and myself, provide clinical evidence of the continuous severity of Mr. Nash's illness and resulting functional deficits from September 2003 to the present. Specifically the severity of Mr. Nash's illness and resulting functional deficits preclude him from performing the duties of his former occupation as documented in his medical records or of any occupation that I can envision. Specifically, in addition to other limitations and restrictions, Mr. Nash is now and has been, continuously from September 2003 to the present, incapable of sitting upright *as required by* even sedentary work.

Mr. Nash's hip condition in January 2005 would be either the same or worse both clinically and radiographically, in November 2005 and January of 2006. Today I have examined Mr. Nash, including x-rays taken in 2003 and January 2006 and the degeneration of his hip has worsened since 2003.

Due to the degenerative nature of Mr. Nash's illness, routine x-rays and detailed range of motion measurements are not necessary for treatment of his condition unless his condition significantly worsens or until such time the patient is preparing for total hip replacement.

Additionally, Magnetic Resonance Imaging (MRI) is not a necessary aspect of treating Mr. Nash's illness.

It is my medical opinion based on my examinations and follow up of Mr. Nash that his **sitting** - is limited to sitting in a reclined position. Restricted to no greater than 30 minutes

forward bent sitting - restricted to no activity of this type;

standing - restricted to periods no greater than 30 minutes at a time with 60 minute

forward bent standing - restricted to no activity of this type;
climbing - restricted to no activity of this type;
balancing - restricted to no activity of this type;

crawling - restricted to no activity of this type;
crouching - restricted to no activity of this type;
stooping - restricted to no activity of this type;
bending to 90 degrees or greater - restricted to no activity of this type;

reaching overhead -- restricted to periods no greater than 30 minutes at a time with 60 minute recumbency in between occurrences;

reaching at desk level - restricted to periods no greater than 30 minutes at a time with 60 minute recumbency in between occurrences;

reaching below waist - restricted to no activity of this type;

use of lower extremities for foot control - restricted to no activity of this type;[30]

restrictions and limitations are: at a time with 60 minute recumbency in between occurrences; recumbency in between occurrences;

The limitations and restrictions resulting from Mr. Nash's illness prohibit him from safely performing many activities. The above limitations and restrictions have been placed upon him since September of 2003 and have remained in place, without suspension, to the present. These restrictions will remain in place until Mr. Nash has a total hip replacement surgery and has been adequately rehabilitated. These restrictions are placed upon Mr. Nash's activities to assist in managing his pain, minimizing additional degradation of his hip joint, and avoiding further illness or injury to him.

In the letters from CIGNA dated December 13/14, 2005 and July 10, 2006, which I have read, desired specific clinical or medical information or clarifications have not been identified to assist CIGNA in understanding Mr. Nash's quite disabling condition. Therefore, I have provided what in my own experience I though might be helpful. That said however, if you should need further information, do not hesitate to write, asking any questions you wish. I will make every effort to provide any further written details you need. I do require written questions to avoid misunderstanding or inaccuracy, and of course a later record for Mr. Nash's patient chart.

[30]Mr. Nash drives only with his right foot, and cannot drive a manual shift automobile.

TN_2APP_Ex0008 - TN_2APP_Ex0010.

In sum, the records related to this man unquestionably document severe disease. He has the nature and level of disease that would produce the classic symptomatology of which he suffers, and a disease level that is fully consistent with the level of excruciating symptoms he suffers when he engages in the activities, postures and positions beyond his pain tolerance. When he has to take narcotic pain medications, because he was unable to control his pain level by activity avoidance or limitation, he suffers from the very cognitive decreases that are typically secondary to narcotic pain medications, which also require avoidance of driving and any activity that may pose danger to the patient. These are precisely the symptoms and secondary effects narcotic pain drugs produce.

Mr. Nash has been left without disability benefits for over a year now. They were terminated December 13, 2005, which means the next payment due 12/31/2005 and each end-of-the month monthly payment thereafter is outstanding. Mr. Nash's claim should be reinstated and the past now-12 months of monthly benefits (beginning with the payment originally due December 30, 2005), together with interest on it at the rate required by the California Insurance Code which regulates the insurance industry in this state. That rate is 10% simple interest.

Very truly yours,

MILLER, MONSON, PESHEL, POLACEK & HOSHAW

Susan L. Horner

Attachment: APPENDIX I

Via fax:	Letter, Appendix and initial exhibits 0001-0010
Certified mail:	Letter, appendix, initial exhibits, medical chronology, claim file exhibits TN_2APP0001-1413

cc: Todd Nash

EXHIBIT G

EXHIBIT G

X-rays	Dr. Tohidi	Stacey Lin	Dr. Padilla 1/4/06 exam + X-ray Dr. Helgager	
Feb 3, 98 July 93 Aug 8, 03 Apr 6, 06	8/8/03 Xray & visit 8/24/03 9/5/03 9/26/03 - disabled 4 mos 1/14/04 4 mos. 5/12/04 (no notes?) 7.5 mos (But saw Dr.Lin @ 5mos) 1/4/05 4 mos 3/31/05 (PAA form) 7 mos 10/19/05 (PAA form) 1 yr 10/23/06 (exam in GA)	11/8/04 11/8/05 3/13/06 (PAA form) 8/10/06	2/9/06 3/29/06 (PAA form) 4/6/06 4/20/06	

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earlier visits
2/3/98
3/13/98
4/27/98

- - - - -

1998		
2/3/98	Dr. Cline A. Handy, LAD LEFT HIP: 2/3/98 An AP film of the pelvis and AP and lateral films of the proximal femur show mild degenerative change with some subchondral sclerosis and osteophyte formation and slight joint space narrowing superiorly and laterally. No acute fracture or dislocation is noted and there is no localized destructive process. IMPRESSION: DEGENERATIVE CHANGE AT THE LEFT HIP.	TN_2APP0051
3/13/98	Dr. Duff Notes regarding left hip exam.	TN_2APP0059
4/27/98	LEONARD R. OZERKIS, M.D HISTORY OF PRESENT ILLNESS: The patient is a 34 y/o male marketer who spends a good deal of time sitting. He had problems as a child with internal rotation of his hips and was told he might need an operation to break his hips and rotate them. He was treated with casts and various other splinting devices and did not have any hip surgery. He did have bilateral knee surgery for various problems. In the last year or two he has noticed increasing difficulty with his left hip with pain in the area and stiffness and difficulty tying his shoe laces. He has never had any trauma to the area. PHYSICAL EXAMINATION: He walks with a slight antalgic gait. There is bilateral long parapatellar scars. Hip flexion is to about 75 degrees, extension is full. There is external rotation on the left side to 15-20°, internal rotation 0 degrees. Abduction and adduction was mildly painful and somewhat limited. Leg lengths appear equal. Peripheral and neurovascular status is intact. **X-RAYS:** Tri-City Medical Center, **2/3/98**: Show slight narrowing of the lateral part of the joint space of the left hip with osteophyte formation and subchondral cyst formation in the acetabular region. There is also some oval shape to the femoral head and on the lateral there is thinning of the lateral femoral acetabular joint" ASSESSMENT: **EARLY DEGENERATIVE ARTHROSIS LEFT HIP.** PLAN: I believe the patient should avoid any impact loading and lose weight. He is currently mild to moderately obese. He has had Naprosyn in the past but without any real result. He should begin a program of stationary bike exercises and Motrin 400-800 t.i.d. with meals, stop if any GI distress. I will see him back in six months for follow-up check. I have explained to him that he will probably need a joint replacement at sometime in the next 5-10 years but he should try to put it off as long as possible. He understands all this and will try to accomplish his goals. LRO/jj cc: Dr. Duff	TN_2APP0039
1999		

7/18/03	Dr. Ajir notes regarding left hip pain.	TN_2APP0055
6/18/03	X-RAY - MILLER, JEFFREY S., MD Accession Number Exam Exam Determine Ordering Provider 1652904 +RT. HIP AFYLAT W/PELVIS 711 812003 15:20 **DUFF, ROBERT, MD** Reason For Exam: OSTEOARTHRITIS 1652904/1652905 **RIGHT HIP: 7/18/03** HISTORY: Osteoarthritis. FINDINGS: Comparison: Pelvis and left hip series of 2/3/98 No evidence of fracture, joint space narrowing, or osteophytosis of the right hip joint. Right sacroiliac joint is unremarkable. IMPRESSION: NEGATIVE RIGHT HIP SERIES. LEFT HIP: Again seen is an apparent old left femoral neck fracture deformity with some remodeling. Again seen as osteophytosis and superior joint space narrowing, which may be slightly increased compared with prior study. No evidence of acute fracture or dislocation. IMPRESSION: POST TRAUMATIC CHANGE OF THE LEFT FEMORAL NECK, APPARENTLY DUE TO OLD FRACTURE WITH MODERATE TO SEVERE LEFT-SIDED OSTEOARTHRITIS SLIGHTLY PROGRESSED COMPARED WITH PRIOR STUDY. Signed By: Transcribed Date and Time: 7/21/2003 17:32 MILLER, JEFFREY S., MD SCHMITTER. STEPHEN P., MD	TN_2APP0005
8/8/03	**AP STANDING HIPS: 8/8/03** HISTORY: Osteoarthritis. COMPARISON: 7/18/03 FINDINGS: **Deformity** of the proximal left (femur is again identified which is presumably related to old trauma. There is severe osteoarthritis with near complete obliteration of the super lateral joint space of the left hip on upright views. No acute fracture, dislocation, or other bone lesion is seen. Mild degenerative changes am identified in the right, hip. IMPRESSION: PRESUMED OLD POST-TRAUMATIC CHANGES OF THE LEFT PROXIMAL FEMUR WITH SEVERE DEGENERATIVE CHANGES As DESCRIBED ABOVE.	TN_2APP0005

8/8/03	**Behrooz Tohidi, M.D.** CHIEF COMPLAINT: Left hip pain. HISTORY OF PRESENT ILLNESS: This 39-year-old right-handed male salesperson in marketing presents today complaining of pain deep inside the left hip, which is constantly present. He also notes popping in the hip and severely limited range of motion. He finds It difficult to put on his stockings, and he is unable to tie his shoes, He is able to negotiate stairs with a modified gait, Long sitting is painful, which he particularly notices when he is traveling overseas, which he does about once a month. His symptoms began insidiously in February of 1998; he was seen by Dr. Duff. Thereafter, he had a consultation with Dr. Ozerkis, who told him that at some time in the future he would probably need a hip replacement but to hold off as long as he could. He denies groin pain or left leg pain. He also denies leg weakness. He had an ACL reconstruction with graft on the right knee 15 to 20 years ago. Both knees are unstable. He injured the left ACL with repeated sports injuries and opted not to have surgery on that knee. **X-rays** of the hips dated **February of 1998 and again July of 2003** are available today. At the present time he is not particularly interested in proceeding with surgery, but he is interested in comparison of the previous films of 1998 and those of most recently to see the extent of deterioration. He is interested in learning of any other measures to control his pain while he is adding more years prior to a hip replacement. ALLERGIES: He is allergic to aspirin. PHYSICAL EXAMINATION: Extremities: The gait is antalgic inconspicuously. He also has a slightly intoed gait. On the standing position he has bilateral flatfeet with metatarsus abductus deformity, mild. There is marked limitation of motion to the left hip with 0 degrees of external rotation, about 30 degrees of internal rotation, 25 dg of abduction, 15 degrees of adduction, and no flexion contractive but flexion of only 50 degrees. He also has slight shortening to the left hip. Neurologic: Unremarkable. Spine: Unremarkable. **X-RAYS**: The x-rays elicit severe posttraumatic degenerative arthritis of the left hip with congruent loss of the articular space and bone-on-bone contact in the weight-bearing dome and in zone 3 of the acetabulum. The patient otherwise elicits with type-B bone in the proximal femur. DIAGNOSIS: **Severe posttraumatic degenerative arthritis of the left hip**. PLAN AND RECOMMENDATIONS: **AP standing hip views are ordered**. This patient has never had an intra-articular injection, which will be undertaken upon return in followup. The long-term effect of the injection will be observed. In my opinion the treatment options include intermittent injections, in my opinion versus a total hip replacement. A hip fusion in this patient will be very debilitating as the present problem is inadequate flexion of the hip and problems with sitting. Behrooz Tohidi, M.D.	TN_2APP0079 - TN_2APP0080

8-14-03	Behrooz Tohidi, M.D. Mr. Nash returns in followup after the completion of the functional x-rays of the hips. The **standing AP hip views** elicit severe degenerative arthritis of the left hip with complete loss of the articular space and bone-on-bone contact. Due to severe anteverted hips, he elicits 155 degrees to 160 degrees of femoral neck and shaft angle, which predisposes him to slight lateral subluxation of the hip bilaterally. The diagnostic and therapeutic injection of the left hip was completed with Xylocaine and Depo-Medrol. Pain relief was noted. The short- and long-term outcome of the Injection was discussed with him. He will return In four weeks for further evaluation at which point It will be determined whether or not he can continue with conservative management or surgical intervention can be Implemented at that time.	TN_2APP0077
9-5-03	Behrooz Tohidi, M.D. Mr. Nash returns to the office for followup. The injection was only helpful for a short-time basis, and the pain has been recurrent in the same-way. He describes severe pain when sitting in a confined area such as a chair or an airplane seat for any length of time, ranging from as little as 45 minutes to 90 minutes. Sitting after 90 minutes increases his pain and Increases the length of time that he takes to recover. His work as vice president in business development in his company requires attending many meeting at both customer locations and within the company's own offices. Meetings can last for several hours with limited breaks and very limited opportunity to move about or reposition himself to avoid pain. Of course, when aboard an airplane he sits anywhere from 90 minutes to in excess of 12 hours. He also, especially when traveling, has to board public transportation such as buses or passenger vans or trains and has to sit for anywhere from 30 minutes to In excess of three hours without being allowed to move around adequately. Driving a vehicle for anything over 30 minutes produces increased hip pain. He states that his job has recently demanded that he travel much more frequently and for much longer distances such as International travel than he previously had to do, and he is finding It increasingly difficult because of his hip pain. He is not able to take anti-inflammatory drugs, and he has not been able to reduce his hip pain with acetaminophen. If he takes narcotics for pain control, he is not in a cognitive state that allows him to perform his job or operate a vehicle in order to get to and from work or, especially while in a foreign country to operate a motor vehicle or seek other transportation while performing his work duties. The treatment options were discussed with him. At this time it is obvious that the Injection did not provide any long-term improvement and therefore, symptomatic treatment and activity modification versus a hip replacement would be the options of treatment. Presently, he does not wish to proceed with a total joint considering his age. He will eventually need such a procedure, but I would recommend that he wait until his symptoms are more severe and more disabling.	TN_2APP0077
9-10-03	Prescription Fill - Behrooz Tohidi MD Qty 40 Hydrocodone/APAP 5/500 TAB	appeal-1,ex. 15 TN2APP0358-370

9-26-03	Behrooz Tohidi, M.D. Mr. Nash returns in followup in regards; to his hip condition. His **pain is essentially intolerable when he is confined to sitting for a prolong period**, i.e., when he travels or when he is in meetings where he has to sit confined to a space for some time. He has reached the point where he is **unable to withstand the extent of the pain and remain functional at his present job description.** The treatment of the hip condition, i.e., the osteoarthritis, will be a total hip replacement, but since he is capable of carrying out his dally living activities, therefore, I recommend that his job be modified to eliminate frequent travel and also frequent meetings so that he can remain functional. If that will not be a possible for him, then I would recommend he be considered disabled. I would like to follow him periodically and, obviously, if his hip pain continues to progress, at some point In the future he will be a candidate for total hip replacement. He understands the long-term plan.	TN_2APP0076
9-26-03 Friday	Date of Disability	

Claimant:	Todd M. Nash (of San Diego x30 yrs)
SSN:	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
DOB:	11/25/1963 (42 ½)
Hired:	4/9/2001
Group LTD insurer	LINA, a CIGNA Co.
Group Policy #:	SLK-030024 (effective 1/1/2000)
Class:	1
Claim #:	
Control #:	
Policy Holder:	Morpho Technologies, San Diego
Occupation:	V.P of Business Development (A sales & marketing occupation), sedentary with some 'light' aspects (in terms of travel)
DOD	Sept. 26, 2003 [41 y.o.]
Disabling Condn:	Severe Osteoarthritis of left hip (post traumatic: accid.years ago)(Can't sit; limited standing & walking); Vicodin-induced cognitive probs when take the med.
Elimination period	14d for STD
STD	26 weeks
LTD Benefits began	3/28/2003
end of 30 mos from disab:	3/26/06
1st claim termination	12/13/05 (stephen eccles)
last benefits payment	11/30/05
1st appeal	6/1/06
2nd Denial	7/10/06, postmarked 7/13/06, **received 7/16/06** (Medha Bharadwaj FLNI, ACS)
2nd appeal (voluntary)	1/4/06
SSA determined disabled;	Benefits as of 3/05: $3060/mo
Salary:	$151,424 x .60 = 90,854 = 7571.20/mo - (3060/mo SSDI) = **$4,511.20/mo LTD**

	Definition of Disabled/Disability The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is either: 1. Unable to perform all the material duties of his or her Regular Occupation or a Qualified Alternative; **or** 2. Unable to earn 80% or more of his or her Indexed Covered Earnings. After Disability has lasted 30 months [2.5 yrs], the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is either: 1. Unable to perform all the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; or 2. Unable to earn 80% or more of his or her Indexed Covered Earnings. The Insurance Company will require proof of earnings and continued Disability. ... **Regular Occupation**: The occupation the Employee routinely performs at the time the p is ability begins. In evaluating the Disability, the Insurance Company will consider the duties of the occupation as it is normally performed in the general labor market in the national economy. **Qualified Alternative**: An occupation that meets all of the conditions that follow: 1. the material duties of the occupation can be performed by the Employee based on his or her training, experience or education; 2. it is within the same geographic area as the Regular Occupation the Employee holds with the Employer on the date the Employee's Disability begins; 3. a job in that occupation is offered to the Employee by the Employer; and 4. the wages for that occupation, including commissions and bonus are 80% or more of the Employee's Indexed Covered Earnings. **Indexed Covered Earnings.** For the first 12 months Monthly Benefits are payable, your Indexed Covered Earnings are equal to your Covered Earnings. After 12 Monthly Benefits are payable, your Indexed Covered Earnings are your Covered Earnings plus an increase applied on each anniversary of the date Monthly Benefits became payable. The amount of each increase will be the lesser of: 1. 10% of your Indexed Covered Earnings during your preceding year of Disability; or 2. the rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.	
9-26-03	Disability Questionnaire, Dr. Tohidi	TN_2APP0007
10-1-03	Medical Request Form signed by Dr. Tohidi	TN_2APP0008

10-8-03	Ltr: Mary Beth Carney General Counsel & V.P. Administration TO Vandalyn Crayton, HR Specialist, Administaff **Re --job description of Todd Nash.** Todd is Morpho Technologies' Vice President, Business Development. As Vice President, Business Development, Todd's duties include such duties as are normally associated with such position, including but not limited to: - design, build and implement Company's business development strategy - participate in the design and development of Company's marketing strategy - participate in the design and development of Company's product management and marketing plan - securing design wins for the Company's products - participating in senior management's efforts to identify and address key operating and financing issues - working with the Company's engineering and R&D to define the product specifications for our roadmap Todd's position with the Company requires his presence in the Company's offices on a regular basis and requires travel to potential customers. The Company considers Todd a **Key employee**.	TN_2APP0739
11-21-03	Physical Abilities Assessment Form signed by Dr. Tohidi Sitting < 2.5 hours in 8-hour day, with "severe L hip pain when sitting in a confined area as a chair or airplane seat, walking over 1/4 mile, standing & climbing stairs. L hip limited motion precludes stopping & crouching. Hip pain occurs in 10-90 minutes with the above activities.". checked < 2.5 hours in 8-hour day for standing and walking, and reaching overhead or at a desk level, checked "no" climbing, balancing, crawling, crouching, stooping, extended work hours, exposure to vibration, or below–the-waist reaching. checked the box of "sedentary" "strength" category limited to 10 pounds	TN_2APP0009 - TN_2APP0010
12-29-03	Ltr: Dr. Tohidi MD (oceanside) to Ms. Vandalyn Crayton, HR Specialist, Administaff Fax 800-620-4785 Mr. Todd Nash remains under the care of Dr. Tohidi for the treatment of severe osteoarthritis of the left hip. Mr. Nash has severe left hip pain when sitting in a confined position such as in a chair or airplane seat, walking over 1/4 mile, standing, and climbing stairs. Left hip limited motion precludes stooping or crouching. Hip pain occurs within 10 to 90 minutes with the above activities. Anti inflammatory medicines have not provided relief of his pain. He has been prescribed narcotic pain medication that precludes cognitive function. Mr. Nash remains incapable of performing his regular work, as described to me in a letter from Mary Beth Carney (General Counsel and VP Administration, Morpho Technologies) dated October 9, 2003.	TN_2APP0967

1-14-04	Ltr: Dr. Tohidi Behrooz Tohidi, M.D. Mr. Nash returns in followup. He states that his **hip condition is essentially the same** and that he more or less has **pain all day, which is aggravated with the various levels of activity**. He specifically states that **sitting is quite painful for him and after about 30 minutes** the pain becomes intolerable, forcing him to mow around. Therefore, it is obvious, in my opinion, that **no further change at this time could be implemented in his activity status or his job description.** He is presently on total disability, which seems to be appropriate. The alternative to the restrictions that were described in his previous job analysis are not applicable to employment by a third party. At the present time he is exploring a self-employment condition where he would be able to accommodate his discomfort at will. This seems to be a reasonable solution and he is presently working on that. Therefore, to clarify the records, In my opinion the restrictions that he has are **limitations of sitting and his tolerance on a subjective and objective basis**, Is about 30 minutes, following which .he needs to move around to relieve the intensity of the pain. He also **has limitation in mobility, such as prolonged standing or walking. A more detailed description of his limitations was addressed in a job analysis form, which also needs to be considered as part of his restrictions.** Because of the intensity of his pain, I had prescribed for him **narcotic analgesics** that he takes periodically when the pain is severe enough that it interferes with his functions of daily living and also sleep. Therefore, based on that aspect of his treatment, he is also restricted In performing any activity that might become hazardous to him while he is taking the narcotic analgesics. As far as the objective aspects of his hip condition are concerned, as mentioned previously, he has **significant limitation of range of motion to the hip with stiffness and an antalgic gait, with radiographic and clinical evidence of endstage hip osteoarthritis.** Since he is presently **taking narcotic analgesics periodically**, this is an issue that likely will be continuous on long-term basis as part of the treatment for him. He is **limited as far as cognitive functions are concerned in regard to the effect of narcotic analgesics.** The eventual treatment for Mr. Nash, as I had mentioned previously, is a total hip replacement, which has a finite life and obviously, because of his age, that treatment has been reserved to be applied in the future. I would therefore recommend that Mr. Nash be followed periodically, and I will see him again in three months.	TN_2App0074 - TN_2App0075
1-14-04	Ltr: Todihi to CIGNA Mr. Todd Nash remains under the care of Dr. Tohidi for the treatment of severe osteoarthritis of the left hip. Mr. Nash has **severe left hip pain when sitting in a confined position such as in a chair or airplane seat, walking over 1/4 mile, standing, and climbing stairs.** Left hip limited motion precludes stooping or crouching. Hip pain occurs within 10 to 90 minutes with the above activities. Anti inflammatory medicines have not provided relief of his pain. He has been prescribed narcotic pain medication that precludes cognitive function. Mr. Nash remains incapable of performing his regular work, as described to me in a letter from Mary Beth Carney (General Counsel and VP Administration, Morpho Technologies) dated October 9,2003.	TN_2APP0908

1-14-04	Disability statement signed by Dr. Tohidi	TN_2APP002
1-14-04	Prescription Fill - B. Todihi MD Qty 40 Hydrocodone/APAP 5/500 TAB	appeal-1,ex. 15 TN2APP0358- 370
1-16-04	Follow-up Medical Request Form signed by Dr. Tohidi	TN_2APP0011
1-16-04	**Physical Abilities Assessment Form** \\ signed, Dr. Tohidi Med: Vicodin Specific restrictions placed on pt: at home: "not perform activities that may become hazardous while taking narcotics" expect functional .... ⊠yes. Limited ROM in left hip precludes ability to perform job function without significant pain. Prescribed narcotic pain medication precludes cognitive function. Can patient RTW at this time if accommodations were made for the listed restrictions? ⊠ yes "Throughout an 8-hour workday, the patient can tolerate, with positional changes and meal breaks, the following activities for the specified duration. (Form list) (⊠ if supported by objective findings) for each of Sitting, standing, walking, reaching at overhead or desk level (but not below waist) checks ⊠ "occasionally (**<2.5 hrs**) for Lifting or carrying, pushing or pulling: checks the column for "Occasionally" after 10 lbs ⊠, writes "None" after anything over 11 lbs. Writes "*None*" after each of the following listed items: climbing ladders, balancing, stooping, kneeling crouching, crawling, ability to work extended shifts, use lower extremities for foot controls.	TN_2APP0012 - TN_2APP0013
2/4/04 and 3/4/04	LINA To: Todihi Requests office notes, laboratory results and any other test results from 09/01/03 to Present. These records may include any tests, office notes, and treatment plans .	TN_2APP0934
5-27-04	Prescription Fill - Behrooz Tohidi Qty 50 Hydrocodone/APAP 5/500 TAB	appeal-1,ex. 15 TN2APP0358- 370
6/1/04	. . . **Notice to LINA that SSA awarded SSDI**. . . .	TN_2APP0607

11-8-04	**Dr. Stacey Lin, M.D.** This is a 40-year-old male who is very pleasant. Tells me he is transferring care so that he can go back to see Dr. Tohidi. Has seen Dr. Tohidi for severe left osteoarthritis with potential for a hip replacement. Was seen by Dr. Duff or "Algiers". Patient tells me that this pain started about six years ago. Does have a history of a motorcycle accident where he actually injured his knee and tore some ligaments, however, did not have any pain at that time at his hip but then was found to have a slight fracture on x-ray. He was last seen by Dr. Tohidi about six months ago. He is on disability and Dr. Tohidi manages this for him. PAST SURGICAL HISTORY: Right knee, left knee as well as his fracture of his left hip. SOCIAL, HISTORY: Nonsmoker. Moderate alcohol. Currently on disability, not actually on too much exercise secondary to pain. He is on Vicodin which probably takes maybe at most one tablet a week. OBJECTIVE: VITAL SIGNS: BP 130/72 , P 78, Resp. 18, Temp 98.2. MUSCULOSKELETAL: On **tenderness to palpation**, not; only on that left hip around the femoral head but his **range of movement** **is only able to lift his knee up off the table about five degrees** otherwise sensation is intact, There is no swelling or edema. ASSESSMENT: History of severe osteoarthritis. PLAN: Pt to get records from Dr. Duff and "Algiers" and will do a signed release for that and for Dr. Tohidi. Okay to get referred back to that once I get documentation.	TN_2App0098 - TN_2App0098
12-13-04	Ltr To Dr. Tohidi from CIGNA Requests: copies of progress notes, diagnostic test and lab results, from 01/04 to the present. Asks him to complete attached **Physical Ability Assessment** form.	TN_2APP0873
2005		
1-4-05	Behrooz Tohidi, M.D. - followup visit. His hip discomfort and pain remain the same. He has **difficulty sitting** and **has developed more stiffness** to his hip. He is essentially unable to sit normally in a chair and has to sit more or less with his hip flexed no more than about 50 degrees. His gait remains antalgic, and he does limp because of the painful left hip. Indeed, range of motion has lessened and he does elicit significant pain with any active or passive motion. He is managing his pain on a conservative level, and obviously he will require a total hip replacement in the future when his pain becomes more or less unbearable. The paperwork presented today by him was completed. He will need to be followed periodically, and I would like to see him again in six months or anytime sooner if his pain would require a more definitive treatment, Therefore a follow up visit (CPT Code 99213) is requested in due time.	TN_2App0073
1-5-05	Prescription Fill Behrooz Tohidi Qty 60 Hydrocodone/APAP 5/500 TAB	appeal-1,ex. 15 TN2APP0358-370

3-8-05	Ltr: Jared Childs to Nash Sends the **Supplementary Disability claim form** to be completed by your current treating physician.	TN_2APP0867
3-19-05	Nash. completed **Disclosure Authorization** authorizes CIGNA to get Dr. Behrooz Tohidi's information & 2003 & 2004 IRS tax return information	TN_2APP0866
3-31-05	Attending Physician Statement supplementary Disability claim form- Dr. Tohidi checked (⊠) - that Mr. Nash was "Unchanged"; - that he was a "Class 5 - severe limitation of functional capacity; incapable of minimal (sedentary) activity, Wrote, "Limited Range of Motion in Left hip precludes ability to perform work activity without significant pain. Prescribed narcotic pain medication precludes cognitive function" "Patient continues to be disabled for any occupation." checked (⊠) that: - Mr. Nash was not a candidate for further rehabilitation services; - that his present job cannot be modified to allow for handling it with impairment; - that "vocational counseling and/or retraining" would not be recommended	TN_2APP0014 - TN_2APP0015
8-26-05	Letter: LINA's **Stephen L. Eccles, ALHC, Case Manager** to Nash . . . asks that Nash **complete the enclosed Disability Questionnaire** sign and date the authorization for LTD assessment	TN_2APP0848
9-1-05	Approximate date Behrooz Tohidi, MD DIRECTOR- SAN DIEGO JOINT REPLACEMENT MEDICAL CENTER announcing the relocation of my practice effective October 1,2005. ...	TN_2APP1245
9-22-05	"file in SIU ten days. 9.22.05 - 10.1.05	
9-23-05	Cx called to say he was putting **DQ** [Disability Questionnaire & Activities of Daily Living] in the mail today. **He also said his AP, Dr. Tohidi is moving to GA from CA.** He said he is due at his new office on 10.1.05. His new ph will be 478.237.7676. Fax will be 478.237.4778. I requested that the cx try to get copies of his chart to send to us before Tohidi moved and the cx agreed, but said that he may have already gone. He said Tohidi was taking his old records with him. Cx said due to his HMO, it may take him a while to get a new specialist as they are not referring to specialists very often. he said if we need an physician statement to give him some lead time for this request.	TN_2APP0589

9-23-05	completed & mailed - **Disability Questionnaire & Activities of Daily Living** Q: In your own words, tell us why you cannot work in your own or in any occupation. A: **Pain in my Left Hip precludes me from staying in the same or similar position for long enough to accomplish tasks associated with an occupation. The limited movement of my hip causes pain and limits my activity. Pain pills limit my cognitive ability to work.** Q: Primary physical and/or mental condition preventing you from working now? A: "Severe Osteoarthritis in my left hip." Q: **Can you drive? A: ☒ yes. How far? [About] 45 minutes** Q: Time up in the morning? "6-7 AM" go to bed? "0-10 pm" Q: # floors in the apt/house? A: "3". Q: do you use any special equipment - ramps, handrails, wheelchair? ☒ Yes "**Handrails for** stairs, various items for getting in & out of seating / laying type furniture. Q: own a personal computer? ☒ yes. Q: Connected to the internet/ ☒ yes Q: computer programs/software you can use? A: "Word, excel, power point, quicken, outlook". Q: How often use computer? "Daily" Q: Check the things you do *regularly:* - the form-listed activities are: cook, clean, shop, laundry, yardwork, gardening, read, watch TV, other. A: .25 hrs/d, 7d/wk: "cook"; 3h/d 7d/wk "Read"; 2 h/d 7d/wk "Watch TV" Q: Recreation? "Attend to my children, read, watch TV" Q: things you attend to w/ regard to personal needs (grooming dressing etc): "I attend to all of [my] personal needs." Q: go for walks? A ☒ yes. 3-4x/wk. 100 yards, about 20 minutes. Answers questions about background & education. Prior jobs. Q: ever owned/operated your own business? ☒Yes. Q: Own/operate or have ownership interest in a business now? ☒Yes. (Todd Nash Financial Planning" began 1/2/04. "Financial planning Q: Prescription Meds: "Vicodin 5/500 frequency: max 8/24 hrs. other Dr. Tohidi @ 3-6 mos. Last visit 3/31/05. 5'8", 230# receives $3060/mo SSDI 6/2/04 to date 9/22/05	TN_2APP1241 - TN_2APP1244 [Note: not the policy disab. definition].
10-19-05	Physical Abilities Assessment (PAA), Dr. Tohidi "Mr. Nash has severe L hip pain when sitting in a confined area as a chair or airplane seat, walking over 1/4 mile, standing and climbing stairs, L hip limited motion precludes crouching. Hip pain occurs in 10-90 minutes with the above activities. Anti inflammatory meds and ASA have not been remedial. Narcotics preclude cognitive function.	TN_2APP001 6- 0017
Oct 25- 29, 05	(THE 4 SURVEILLANCE DAYS.)	

Received 12-21-05	**BENEFITS TERMINATION Ltr** ; Eccles: We have completed our review of your claim for Waiver of Premium (WOP) on your Group Life Insurance policy and regret to inform you that you are not eligible. Your CIGNA Life Insurance policy contains the following provisions: Waiver of Premium "If an Employee is under age 60 and his or her Active Service ends due to Disability, Basic Life Insurance Benefits as shown in the Schedule of Benefits will continue until the earliest of the following dates. - The date the Employee is no longer Disabled. - The date he or she no longer qualifies for Waiver of Premium. - The day after the period for which premiums are paid. - The date the Maximum Benefit Period for this benefit, if any, ends. - If an Employee dies while premiums are waived, the Insurance Company will pay a Death Benefit only if due proof of continuous Disability is received within one year of his or her death." Termination of Waiver "Insurance will end for any Employee whose premiums are waived on the earliest of the following dates. 1. The date he or she is no longer Disabled. 2. 3. 4. The date he or she refuses to submit to any physical examination required by the Insurance Company. The last day of the 12 month period of Disability during which he or she fails to submit satisfactory proof of continued Disability. The date the Maximum Benefit Period for this benefit, if any, ends." **Overview of Eligibility of Benefits** We reviewed the following information in conducting our review: 1. A Physical Ability Assessment from Dr. Tohidi completed 10.19.05 2. An Attending Physician statement completed by Dr. Tohidi on 3.31.05 3. Disability Questionnaire signed 9.22.05 4. Tax returns for 2004 5. Surveillance conducted from 10.25.05 through 10.29.05 On 8.30.05, we sent a letter to you requesting you complete an Activity of Daily Living Questionnaire and a Disclosure Authorization. Dr. Tohidi states that you have hip pain secondary to severe osteoarthritis on his Attending Physician statement dated 3.31.05. He notes you have pain and limited motion in the left hip. As of that date, your last office visit was 1.4.05 and you saw him every 3-6 months. He provided a Physical Abilities Assessment on 10.19.05 where he states you have osteoarthritis in your left hips, and comments that it is severe. Cont.	TN_2APP1184

12-21-05 cont	Termination letter cont./.// We attempted to get office notes from Dr. Tohidi and he has not responded to our request. We also attempted to obtain records from Dr. Ajir and Dr. Lin. On 11.28.05, we sent you a letter requesting these records by 12.12.05 and to call our office by 12.8.05 to ensure that we received the records. You called our office on 11.30.05 and provided phone numbers for the doctors and said we could obtain the records from them directly. We faxed a request for their records on 11.28.05 using the restricted authorization you had provided for us. Your authorization limited release of medical records to those directly relating to your disability. Dr. Ajir responded to our request for records on 12.5.05, but the last visit you had with this office was 11.18.03 .) Dr. Lin never responded, nor did Dr. Tohidi. - Surveillance was conducted for a period of five days. During this time, you were observed doing the following activities: **Wednesday, 10.26.05** **Thursday, 10.27.05** - Carrying a 4' x 8' sheet of drywall in the store, loading it in your car and unloading it at home; during this activity, you bent at the waist and lifted the drywall with both hands. While at home, you lifted the sheet of drywall over your head as you carried it across your street and up your driveway - Unloaded car, including scrap pieces of plywood - Driving to Blockbuster's in Carlsbad and walking to return a movie - Shopping at True Value hardware adjacent to Blockbuster - Talking with construction workers around your home - Driving to and entering a building on Jefferson in Carlsbad where you stayed approximately 1% hours - Picking up a male child at a Church on Fire Mountain in Carlsbad - Shopping at True Value Hardware in Carlsbad - Walking around your residence and talking with various construction workers and neighbors - Cutting a piece of PVC pipe in your garage using both hands and standing up while cutting the piece - Carrying a shovel and digging with the shovel in an area where cement was being poured - Carrying a bucket of dirty water out of the garage and dumping it on the grass in front of your home - Climbing a ladder in your garage and reaching overhead to retrieve an object that was stored there - Carrying a level from your garage to an area where workers were apparently installing a fence -Carrying pieces of 2" x 4" lumber and a piece of lattice from your garage to your trashcan - Filling a bucket with water, carrying it to the bottom of a hill in front of your house and dumping it out cont.	

12-21-05 cont	Cont. - Putting a plastic sheet over rocks in your driveway. Using both feet to scrape cement off the driveway and washing it away - Working with the fence posts using a drill - Carrying wood to the work area in your yard - Leveling dirt around the fence area with both feet - Carrying paper towels and duct tape to the workers at your residence - Taking a trash can that was full from the house to the trash receptacles at the side of your home and dumping it out **Friday, 10.28.05** **Saturday, 10.29.05** - Traveling to Witch Creek Winery where you proceeded to work from approximately 10:30 am until you left at approximately 2:30 pm. During this time you were observed stirring large vats with a stick using both hands and standing during this activity, using a hose to wash out a bin that apparently had grape juice in it, pulling a large bin out onto the sidewalk and pushing it to the other side of the building against the wall, hosing out a square bin that was full of grape juice, lifting plywood and walking over uneven ground and scrubbing a large rectangular bin with a brush - Pushing a wheelbarrow down the hill from your residence to a rock pile on the street to the right of your residence - Loading a bucket with rock from the pile, putting it in the wheelbarrow and wheeling it back up the driveway - Carrying the bucket back to the pile of rocks in the street - Trip to the San Diego Zoo. You remained at the zoo from 9:16 am until 1:OO p.m. During this time, you were observed doing the following: - Unloading strollers from your vehicle - Pushing a double stroller with children in it - Walking up a hill pushing the stroller with two children - Walking to numerous exhibits in the zoo, up and down hills, etc. - Running up a fairly steep hill with the double stroller (no children were in it at this time). - Lifting a small boy with both hands up onto a railing to observe an animal display. - Walking up a steep hill that was restricted to anyone in a wheel chair. - The person conducting the surveillance said you walked with a normal gait and exhibited no observable limitations in. your motions while working, walking, bending and lifting. He obtained a total of 240 minutes of video recording of you performing the activities noted above. After review of the medical information in your claim file and the surveillance tapes, it appears you have the capabilities working in your normal occupation, as defined in the national economy. We have no medical evidence to show that you are disabled a t this time from working in your Regular Occupation and therefore, your benefits are denied.	

12-21-05 cont	cont Request for Reconsideration (Appeal) If you disagree with our determination and intend to appeal this claim decision, you must submit a written appeal. This appeal must be received by us within 180 days of receipt of this letter and should be sent to the Life Insurance Company of North America representative signing this letter to the address noted on the letterhead. You have the right to submit written comments as well as any new documentation you wish us to consider. If you have additional information, it must also be sent for further review to the address noted on this letterhead, within 180 days of receipt of this letter. Additional information includes, but is not limited to: physician's office notes, hospital records, consultations, test result reports, therapy notes, physical and/or mental limitations, etc. These medical records should cover the period of January 1, 2005 through present. You may also wish to have **your physician(s) provide** some or all of the following: - Copies of any other **diagnostic test results** which document the severity of your condition to the extent that you are unable to perform the duties of your occupation or any occupation. Please include copies of any recent test results performed (in the last 6 months). In the absence of such report we shall assume that these revealed normal findings and unimpaired function. **Specific/limitations/restrictions** that preclude you from performing the duties of your regular occupation or any occupation. What specific essential job functions, activities of daily living, and social/recreational activities are you incapable of performing? A **discussion by your treating physician(s)** of the medical evidence which prevents you from performing the duties of your occupation or any occupation. What are the **current data sources** used to make these determinations? A **discussion by your treating physician(s) describing your current and future treatment plan(s).** What are the problems of treatment? What are the treatment goals? What are the treatment strategies for each goal? How does the treatment plan address you returning to work? Under normal circumstances, you will be notified of a decision on your appeal within 45 days of the date your request for review is received. If there are special circumstances requiring delay, you will be notified of the reason for delay within 30 days of receipt of your request, and every 30 days thereafter. A final decision will be made no later than 90 days. Please note that you have a right to bring legal action regarding your claim under the ERISA section 502(a) if your appeal is denied. Unless special Circumstances exist, this administrative appeal process must be completed before you begin any legal action regarding your claim.	

12-21-05 cont	Cont. If you believe all or part of your claim has been wrongfully denied or rejected, you may have the matter reviewed by contacting the: CA Dept of Insurance. Consumer Claim Practices Review Unit 300 S . Spring St., South Tower , Los Angeles, CA 90013 Within CA, call (800) 927-HELP (4357) or 800-482-4TDD for TDD. Out of State, dial (213) 897-8921. Requests can be sent by fax to (213) 8974961 Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein. Under the terms of your Group Insurance contract, you have the right to convert all or part of your Group Life Insurance to an individual policy by writing to the address provided below within 31 days of this letter. You are under no obligation to purchase this coverage if you send for the application. However, by sending for the application, you will be provided with the relevant information pertaining to the conversion option including the rates which would be applicable to your policy. We do not carry conversion applications in the Dallas Claims Service Center, nor are we able to quote policy rates. If you wish to apply for conversion, please write or call: IBS; P 0 Box 1326 Fort Worth TX 76101-1326 1-800-423- 1282 If you have any questions, please contact our office at 1-800-352-0611, extension 1292.	
12-14-05	Ltr: Nash to Eccles, cc to Misty Ferris, Doryne Storms I am in receipt of the letter advising me that my claim for benefits has been denied. This letter is NOT to advise CIGNA that I am formally appealing that decision but to request that benefits for the first 30 month portion of my claim against the contract covering me be immediately reinstated while I fulfill the requirements of the formal appeals process. This request is based upon the following: 1. My condition has not significantly changed for the better or worse since my original disability claim in 2003. Documentation of this fact is included in the medical files that are currently in CIGNA's possession, specifically, the Physical Abilities Assessment that contains Dr. Tohidi's recommendations as of October 19, 2005 governing my "8 hour workday" employment activity. As a result, I am unable to perform the material duties of my Regular Occupation or Qualified Alternative nor am I able to earn more than 80% or more of my Indexed Earnings as defined in my disability contract. In multiple conversations with Steve Eccles, he verbally advised me that if new medical information was not available that my claim would be evaluated "using the existing information in your file." This existing information was the basis for the originally approved claim and therefore should be justification for the continuance of the claim. cont.	TN_2APP1191 - TN_2APP1192

	cont 2. CIGNA has neither offered nor provided medical examinations or reimbursement for such examinations, as provided in my disability coverage contract. My orthopedic surgeon has recently relocated his practice out of my state and is no longer able to see me for more visits. In order to see a different orthopedic surgeon I must see my primary care physician and receive a referral. As the result of receiving my medical insurance coverage from a HMO I am unable to see the necessary doctors just to obtain information for my disability insurance provider. This limitation has been verbally communicated during multiple phone conversations with Steve Eccles as well as with a CIGNA case nurse in a recent conversation as the reason for my inability to obtain the requested medical information to support my claim. Despite this limitation of my HMO policy, CIGNA has neither offered nor provided medical examinations or reimbursement for such examinations, as provided in my disability coverage contract. 3. I am unable to perform the material duties of my Regular Occupation or Qualified Alternative. No observation of me by or on behalf of CIGNA shows any activity on my part that is related to my Regular Occupation or Qualified Alternative nor does it show any activity that would enable me to earn more than 80% of my Indexed Earnings as defined in the contract that covers my benefits and as defined in the records of my case. This includes the definition of my duties as defined in the a letter dated October 9, 2003 from Mary Beth Carney, General Counsel and Vice President Human Resources, Morpho Technologies, to Vandalay Crayton, Human Resources Specialist, Administaff. This letter should be in CIGNA's files.4. I am not currently employed nor have I been since working for Morpho Technologies prior to my claim for benefits. This has been documented on my 2004 tax return and will be documented on my 2005 tax return. Based on the above facts I request that you reinstate that benefits for the first 30 month portion of my claim. Please advise me, in writing via fax (760-729-6823), as to your response to this request.	
12-14-05	Ltr: Nash to Eccles Asks a copy of surveillance tape, and any other information from the surveillance. . . and copies of all information that CIGNA has used in determining my eligibility to receive benefits.	TN_2APP1193
12-14-05	Ltr: S. Eccles to T.Nash Sends copy of claim file and copies of the surveillance video CD's We will not open your claim at this time. In order for the claim to be reopened, you will have to submit a Request for Reconsideration (Appeal) as outlined in our letter of 12.13.05.	TN_2APP1189 same TN_2APP1227

12-19-05	**Stacey Lin, M.D.** This is a 42-year-old male who has come in secondary for follow up. The patient was last seen by me November 8. At that time needed a referral to go back to see Dr, Tohidi who has been managing him for severe osteoarthritis of his hip. Since then, Dr. Tohidi has left for Atlanta and so he is here for medication refills. This is secondary to a motorcycle accident and again fracture. The question was whether he needed a hip replacement. The patient continues to have a **lot of pain, particularly decreased range of motion,** only about 5 degrees to lift his knee up off the table. There is no swelling or edema. He is still on the Vicodin. He avoids taking this medication due to decreased mentation and inability to drive on the medication. The pain is off and on. He has **good days and bad days.** What is helpful is if he reclines. **Sitting is the worst** in that he has pain as well as **decreased sensation** after about 15 minutes. No urinary difficulties; **particularly worse with different activities such as showering or putting on his socks.** He does tell me that his Disability has been discontinued. This is secondary to lack of documentation. Apparently, there, is a fax to this office from medical records, but I do not see any record of this fax. PHYSICAL EXAMINATION VITALS: BPr 164/94. The patient tells me at Sav-On it is usually 135-119 systolic. PULSE: 80. RESPIRATIONS: 16. GENERAL: No acute distress. MUSCULOSKELETAL: Again, tender along that hip, particularly the left hip. ASSESSMENT: History of severe osteoarthritis. PLAN : With Dr. Tohidi gone, will refer to Dr. Padilla. The patient is to follow up with him. He also tells me that he is appealing this disability decision and therefore will await his request for records at that particular time. Apparently Todd also has Some sort of waiver that states that he needs to be faxed information as well if there is any sort of release of information to his lawyer.	TN_2App0096 - TN_2App0097
12-19-05	Prescription Fill Stacey Lin Qty 50 Hydrocodone/APAP 5/500 TAB	appeal-1,ex. 15 TN2APP0358-370
12-30-05	Ltr: Nash to Eccles Asks for "me a copy of the original, unedited video (and audio if available) in its original format or advise me as to how I may obtain this information on my own.	TN_2APP1185
1/4/06	Horizontal AP Pelvis and attempted Frog Lateral Left Hip	

1-4-06	Dr. Patrick Padilla, M.D. CC: Left hip pain. **HPI**: Mr. Nash is a 42-year-old male, who complains of left hip pain secondary to osteoarthritis. The patient states that he's been followed by Dr. Tohidi for several years and due to the fact that Dr. Tohidi has left the area and is no longer practicing, is referred for evaluation. The patient describes significant limitation of range of motion of the left hip as well as difficulty with foot wear and foot care of the left foot. He denies numbness or weakness in the left lower extremity. The patient does not currently ambulate with aids. He states that he uses occasional Vicodin "a couple per month" for pain relief. The patient denies a history of my specific trauma to the left hip. **MEDICAL HISTORY** - Details of the patient's past medical history are noted in the chart. **PHYSICAL EXAMINATION**: Examination of his left hip and lower extremity - there is a leg length inequality of right greater than left of approximately 1 cm. **Left hip range of motion** - Forward flexion approximately 45degrees, 0 internal or external rotation, abduction of approximately 10 degrees with minimal hip extension. Knee, ankle and digital range of motion is full distally. Distal motor/sensory/vascular exam is intact. There is no gross atrophy. There is no significant tenderness to palpation about the hip. **XRAYS** [horizontal; 1/6/2006]: Including AP Pelvis and attempted Frog Lateral Left Hip: Shows severe degenerative arthritis with joint space narrowing, osteophyte formation. There is no evidence of putrusio. **IMP**: Severe left hip osteoarthritis **PLAN**: I have discussed treatment options and recommendations with the patient. The patient has not undergone a consistent course of oral anti-inflammatories as well as the use of ambulatory aids such a cane, intraarticular Corticosteroid injection or total hip arthoplasty. Based on the patient's age and severity of the disease I feel that it is likely that he is not going to gain a significant time period with these conservative or minimally invasive efforts. My recommendation would be to undergo a surface replacing hip arthoplasty rather than the conventional total hip arthoplasty, I feel that this is a bone-sparing procedure and may provide the patient with greater long term options. Currently this procedure is only done in a limited number of institutions. I believe that the patient should be provided with a referral and consideration of this procedure as this is an unusual situation, I believe it is in the patient's best interest to be considered for this procedure. The patient indicates he is willing to undergo a course of oral anti inflammatories with Naprosyn 500 mg po bid. The patient will be reevaluated in three weeks.	TN_2App0118 - TN_2App0119
1-6-06	Ltr: Eccles to Nash Advising LINA doesnot have "a copy of the original, unedited video (and audio if available) in its original format. " PhotoFax Inc has it.	TN_2APP1201 And TN_2APP1226
1-18-06	Dr. Padilla - Addendum: Per pharmacist recommendations will d/c Naprosyn due to aspirin allergy.	

2-9-06	James A. Helgager, M.D. **History of Present Illness:** Todd is a 42-year-old right hand dominant male with osteoarthritis of the left hip which has been present for several years. The patient was seen in this office by Dr. Ozerkis. He has also been seen by Dr. Duff, Dr. Stacey Lin, and Dr. Tohidi. Dr. Tohidi initially evaluated Mr. Nash in August of 2003. Diagnosis of **advanced osteoarthritis** of the left hip was made, Since being seen by Dr. Tohidi, the patient has had one cortisone injection to his hip performed by Dr. Tohidi in his office. He has tried some anti-inflammatories which actually have not worked well. The patient is not able to take aspirin, so he is currently managing his condition with activity modification and Vicodin. The patient is generally doing okay. He has been well counseled in the past regarding the pros and cons of total hip replacement in regards to his age and options of treatment. PAST MEDICAL HISTORY: His past medical history reveals history of a right ACL reconstruction many years ago with re-rupture of ACL. **ALLERGIES:** Patient is allergic to aspirin. **MEDICATION:** Vicodin REVIEW OF SYSTEMS: - Unremarkable for heart disease, respiratory disease, GI or GU illnesses. **PHYSICAL EXAMINATION:** Patient walks with minimal antalgic gait on the left. He has marked restriction of left hip motion with flexion about 70 degrees, minimal rotation, abduction 10 degrees, adduction 10 degrees. There is no significant shortening. There is evidence of prior ACL reconstruction with long midline incision with obvious knee instability. The patient is not able to sit without reclining back because of the stiffness of his left hip. **RADIOGRAPHIC EXAMINATION:** X-rays reveal advanced osteoarthritis of the left hip. These are from January 4, 2006. **ASSESSMENT: ADVANCED OSTEOARTHRITIS LEFT HIP** **DISCUSSION:** The patient is 42 years of age and at this point is still getting along relatively well. I would not recommend total hip replacement at this time. I would think that the patient could consider trying, if his symptoms worsen, Clebrex which is a COX-2 inhibitor or an interarticular steroid injection done under image control. If patient comes to a total hip replacement surgery, then the outlook for this surgery is excellent although, he is quite young, and we certainly could not guarantee that he would not require revision hip surgery. I discussed with him use of metal on metal because of his age or possibly ceramic on ceramic if he comes to hip replacement surgery. In addition, I did discuss with him that there are some new designs for hip resurfacing that possibly would offer the patient another solution. I will see the patient in a year with x-rays. Patient will need help with his papers for disability because of his hip arthritis. The patient cannot sit in a chair for any significant period of time and thus is not able to work. **WORK RESTRICTIONS:** Patient is not capable of working at his previous job because he is unable to sit either in a chair or plane because of pain and because his hip is so stiff he is not able to sit upright and must recline.	TN_2App0120 - TN_2App0121

2-13-06	**Stacey Lin, MD** This is a pleasant 42-year-old male who has come in secondary to discussion about his hip pain. The patient has a history of severe osteoarthritis. He was initially being seen by Dr. Tohidi who is also helping him with his disability. Dr. Tohidi, unfortunately, has left the state and, therefore, was referred to Dr. Padllla. Unfortunately, he did not get along very well with Dr. Padilla and, therefore, saw Dr. Helgager last week and tells me that he had a much more conducive relationship with Dr. Helgager and is happy to stay with him. The plan, however, is to continue with the current care considering his age. They are trying to prevent multiple revisions and the request is to delay any sort of surgical intervention at this time Of note, I do not have Dr. Helgager's note at my office at the time of this time dictation. I do, however, have Dr. Padilla's note from his evaluation on January 4. It looks like from Dr. Tohidi's notation as well as Dr. Padilla's examination that there has been no significant change in the patient's condition at least from January 2005. It does look like Dr. Padilla had his forward flexion only at 45 degrees. He is sitting a bit leaned back today in the room to about 70° and he does tell me that Dr. Helgager gave him a 70° range of motion. It sounds like the plan, according to the patient, with Dr. Helgager is to maintain his current regimen and his current activity plan. He is unable to sit for prolonged periods of time given the significant limitation of range of motion of his left hip. It does look like his job description, however, requires him to sit for: significant amounts of time. This patient has asked me t o fill out a physical abilities assessment form. We did go over this today. It looks like there has been no change from his previous visit with Dr. Tohidi. I have talked to him about having Dr. Helgager make this assessment as well, but I have also made the recommendation of following with occupational medicine here at my office so that he could possibly do a functional capability test. I have looked over this physical abilities assessment form. What I have elected to do is to maintain the same level of Dr. Tohidi's assessment. This is corroborated by Dr. Padflla's physical exam and I will request that note from Dr, Helgager as well. I will not complete this form until I get Dr. Helgager's note, however. **ASSESSMENT: Severe left hip arthritis.** **PLAN :** We have discussed treatment options as well as recommendations. This patient has already gone through articular cortisone injection. It does look like Dr. Helgager will be corroborating with Dr. Tohidi's assessment; at least this is per patient. I will corroborate this with plea issue of getting Dr. Helgager's note and please see amendment in this chart. I recommended that the patient stay at his activity level and based on what looks like he is providing me a job description of, it is recommended that he sit most of the time which he is unable to do with his range of motion. Given his level of pain and limitations, it does not look like he is able to significantly sit, bend, walk, kneel, or reach, and especially any sort of what looks like extended hours. Again, I have requested that he seek occupational medicine to help with his assessment as well as will request any sort of notations from Dr. Helgager. Please see amendment in chart for continuation of this dictation.	

3-13-06	**Physical Abilities Assessment Form** signed, Dr. Lin Limited to less than 2.5 hours in an 8 hour day os sitting, standing, walking, reaching overhead or at desk level, no climbing, balancing, crouching, stooping, crawling, work of extended hours. Mr. Nash was seen by Dr. Tohidi and is now managed by Dr. Helgager who will evaluate him for his disability. His exam is unchanged since my first visit with him. Essentially, with his L severe hip pain, he cannot sit for a prolonged period of time. Anti-inflammatories do not help and narcotics affect cognitive function. He is currently and will be managed by Dr. Helgager for future disability paperwork."	TN_2APP0018 - TN_2APP0019
3-22-06	**Physical Abilities Assessment Form** signed, Dr. Helgager checks the boxes that Nash was, as supported by objective findings, limited to less than 2.5 hours in an 8-hour day of sitting, standing, walking, kneeling, no climbing, balancing, crawling, crouching or stooping or reaching below the waist.	TN_2APP0020 - TN_2APP0021
3-29-06	Prescription Fill - Stacey Lin Qty 50 Hydrocodone/APAP 5/500 TAB	appeal-1,ex. 15 TN2APP0358-370
3-30-06	**Functional Capacity Evaluation** - See data and findings in the report -	TN_2APP0023 - TN_2APP0038
4-6-06	X-ray: LEFT HIP INJECTION UNDER FLUOROSCOPY: 4/6/06 (Read by Sclimitter MD, Stephen P.) TECHNIQUE: Consent was obtained from the patient following discussion of procedure, risks, and benefits. The patient was supine on the fluoroscopy table and the left hip joint was localized using fluoroscopy. The overlying skin was sterilely prepped and draped and anesthetized using 1% lidocaine. A #20 gauge spinal needle was then advanced into the joint space. Positioning within the joint space was confirmed with injection of small amount of contrast and air. A mixture of 2 cc Kenalog and 2 cc of Sensorcaine was injected to the joint space. The needle was removed and skin dressed. Patient tolerated the procedure well without any immediate complication. FINDINGS: Radiographs demonstrate **severe degenerative disk disease of the left hip.**	TN_2App0001

4-20-06	**James A. Helgager, M.D.** S: Todd returns to the office for evaluation. He had his left hip injected several weeks ago. This really is not helping particularly. He continues to have pain and limitation of motion. He is functioning at the point. He does not want to proceed with hip replacement or resurfacing at this time. ALLERGIES: The allergy to aspirin causes hives. **O:** The patients range of motion reveals that he is able to flex his hip to about 70 degrees. He has about 15 degrees of internal and external rotation. Abduction is 40, adduction is 20 degrees. Patient has very minimal shortening, 2mm shortening. Distal pulses maintained. There is no hip instability. Knee exam is unremarkable. DTRs are symmetrical. There is no motor or sensory deficit. **P:** The patient brought to me some notes regarding his medical records, which he would like entered. Patient state, and I would concur, that he has not had any change in his symptoms since January 2005. The patient has not been helped with injections or physical therapy. He continues to take anti-inflammatory medicines. Patient indicates he is not able to do his job because of his inability to sit for long periods of time at a desk or on an airplane. He has pain and because of the lack of motion is unable to sit. The patient is incapable of flexing his hip beyond 70 degrees at this time. He will continue to utilize over-the-counter or prescription anti-inflammatory meds and occasional Vicodin. Vicondin can cause dizziness, and patient should not drive while taking Vicodin. I would suggest the patient delay his surgery if it is conceivable that he is able to carry out his activities of daily living. In regards to his work activities, if hip replacement surgery or resurfacing procedure was done, he would probably be able to return to his job. The patient will have to make the decisions whether he wants to proceed with surgery with this in mind. The patient has a significant allergy to aspirin, and, therefore should not take anti-inflammatory medicines. I would recommend that this patient undergo a hip replacement or resurfacing procedure in the future. The timing of the surgery is based on the patient's personal situation. Certainly, his hip arthritis makes him a candidate at this time. He is, however, only 42 years of age, and if it is conceivable to delay the surgery for a decade, that would be best.	TN_2App0122
5-30-06	Ltr: from LINA's Medha Bharadwaj, FLMI, ACS, Centralized Appeal Team 5th floor, to Nash As noted in our denial letter of December 13, 2005, we will consider any additional relevant information ....complete file is being considered during the appeal review process. A final decision will be made no later than 45 days from receipt of your initial request for appeal, with an additional 45 day extension allowed if necessary and due to good cause. . . . . We will notify you once we have reached a determination on your appeal. If additional information is needed or there is a reason for delay, we will contact you. At the latest, we will contact you every 30 days.	TN_2APP1091 - TN_2APP1091
6/9/2006	Prescription refill: Vicodin	

6-30-06	**OCCUPATIONAL REVIEW** - Alan Ey The duties or tasks described in the above referenced letter are as follows: design, build and implement Company's business development strategy participate in the design and development of Company's marketing strategy participate in the design and development of Company's product management and marketing plan securing design wins for the Company's products participating in senior management's efforts to identify and address key operating and financing issues working with the Company's engineering and R&D to define the product specifications for our roadmap . . . the claimant was considered a "key employee" and that he must travel to potential customers. Based on the scope of these duties as well as the level at which they were performed, the best match with the DOT is with DOT# 189.1 17-034 (**Vice President**). This match takes into account that the claimant was a key contributor and that his level of compensation was in the executive range. . . . The DOT categorizes this occupation at the **sedentary exertional level.** Sedentary work is that which requires occasional lifting to 10 pounds and which is **performed, primarily, while seated**. . . . **the essential job functions do not exceed the sedentary exertional level,** the activity (travel) necessary to perform those functions exceeds sedentary work.	TN_2APP1066 - TN_2APP1067
6-30-06	Response emailed to appeals specialist on 6/30/06. A. Ey	TN_2APP1123
7-10-06	**2nd DENIAL Ltr: Bharadwaj** We have carefully reviewed your claim for Long Term Disability (LTD) benefits, in accordance with [ERISA] and must affirm our previous denial of your claim. Please refer to our December 13,2005 letter for specific policy definitions and previously reviewed information. In order to qualify for continued [LTD] Benefits, you must continue to meet the Definition of Disability as follows: **Definition of Disability** "The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is either: 1. unable to perform all the material duties of his or her Regular Occupation or a Qualified Alternative; or 2. unable to earn 80% or more of his or her Indexed Covered Earnings. After Disability has lasted 30 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is either: 1. unable to perform all the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; or 2. unable to earn 80% or more of his or her Indexed Covered Earnings." **Disability Benefits** - "The Insurance Company will pay Disability Benefits if an Employee becomes Disabled while covered under this Policy. Cont	TN_2APP1061 - Life TN_2APP1063

7-10-06	cont. 2nd **DENIAL Ltr** The Employee must satisfy the Elimination Period, be under the Appropriate Care of a Physician, and meet all the other terms and conditions of the Policy. He or she must provide the Insurance Company, at his or her own expense, satisfactory proof of Disability before benefits will be paid. The Disability Benefit is shown in the Schedule of Benefits. The Insurance Company will require continued proof of the Employee's Disability for benefits to continue." **Termination of Disability Benefits -** "Benefits will end on the earliest of the following dates: 1. the date the Employee earns 80% or more of his or her Indexed Covered Earnings; 2. the date the Insurance Company determines he or she is not Disabled; 3. the end of the Maximum Benefit Period; 4. the date the Employee dies; 5. the date the Employee refuses, without Good Cause, to fully cooperate in all required phases of the Rehabilitation Plan; 6. the date the Employee refuses, without Good Cause, to fully cooperate in a Transitional Work Arrangement; 7. the date the Employee is no longer receiving Appropriate Care; 8. the date the Employee fails to cooperate with the Insurance Company in the administration of the claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due. Benefits may be resumed if the Employee begins to cooperate fully in the Rehabilitation Plan or a Transitional Work Arrangement within 30 days of the date benefits terminated." **Overview of Eligibility of Benefits** We based our decision on your claim for benefits upon Policy language and all documents contained in your claim file, viewed as a whole. The following information was reviewed as part of your appeal: **Exhibits 1 through 37** I am aware that you have been off work since September 29, 2003 due to osteoarthritis of the hip. As stated to you in our letter of June 20,2006, we conducted a **medical review**. As part of his review, our **medical director** reviewed all the medical information contained in your claim file. After review of the entirety of the medical information in your file, our medical director noted that **most of the medical information provided were several years old and prior to when your Disability benefits ended.** Our medical director noted that you saw various physicians From December 2005 to April 2006 and also underwent a FCE in March 2006. However **this information is several weeks to several months after your Disability benefits ended and does not provide evidence of continuous Disability as of November 30,2005**, when your benefits ended. Our medical director also stated that although surgery was recommended 6 weeks after your benefits ended, the medical records in file do not support severity of any condition as of November 30,2005 that would support limitations and/or restrictions precluding you from performing your occupation. Cont.	TN_2APP1061 - Life TN_2APP1063

7-10-06	cont. **Summary** Mr. Nash, the policy provides that [LINA] would pay benefits only if you met the policy's requirements. Disability is determined by medically supported limitations and restrictions which would preclude you from performing the duties of your light occupation as a **Vice President**. The presence of a condition, diagnosis or treatment does not equate disability under the plan. While the documentation on file described your conditions, it does not provide **clinical findings** that would support the **severity of your condition and functional deficits** that would preclude you from performing your occupation as of November 30, 2005, when your [LTD] benefits ended. As such, we are reaffirming our previous denial decision of December 13,2005 within the meaning and terms of your group Long Term Disability plan. **You may request a review** of this decision by writing to the [LINA] Representative signing this letter at the address noted on the letterhead. The written **request for review** must be sent **within 180 days** of the receipt of this letter. In addition to any written comments, your request for review must include **new documentation** you wish us to consider. Under normal circumstances, you will be notified of a decision on your appeal within 45 days of the date your request for review is received. If there are special circumstances requiring delay, you will be notified of the reason for delay within 30 days of receipt of your request, and every 30 days thereafter. A final decision will be made no later than 90 days. Please note that you have a right to bring legal action regarding your claim under the ERISA section 502(a). You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local United States Department of Labor Office or your State Insurance Regulatory Agency. Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein.	TN_2APP1061 - Life TN_2APP1063

Ltr: Nash to Bharadwaj & Karol Johnson

. . . Per the letter dated December 13, 2005. . . , my claim was denied on December 13, 2005 with the payment of benefits retroactive to the last payment date of November 30, 2005. My file shows that my claim was active up to and including December 13, 2005 in contradiction to statements made in Ms. Medha Bharadwaj's letter.

Ms. Bharadwaj states in her appeal denial letter that, "... our medical director noted that most of the medical information provided were several years old and prior to when your Disability benefits ended."

The medical information provided to CIGNA was obtained as a result of determining a diagnosis, prognosis, and a treatment plan for my illness.

Additionally, much of the medical information obtained was done so at the request of CIGNA in order to support my claim for Disability benefits. Therefore, this information was obtained mostly at the onset of my Disability and at times dictated solely by CIGNA. Once I was on a treatment plan consistent with contract SLK-030024's definition of Appropriate Care, I then obtained medical information as necessary to treat my illness and to provide requested information to CIGNA. The age of the medical information is consistent with CIGNA's requirements and requests as communicated to me by CIGNA.

Ms. Bharadwaj goes on to state that, "... that you saw various physicians From December 2005 to April 2006 ..." and that, "However this information is several weeks to several months after your disability benefits ended and does not provide evidence of continuous Disability as of November 30, 2005, when your benefits ended."

This analysis is incorrect in that **I was seen by Dr. Stacey Lin within 6 days of Mr. Eccles' letter terminating Disability benefits**. This time line was not "several weeks to several months" after my Disability benefits were terminated. **The office visit with Dr. Padilla was not 6 weeks after CIGNA terminated my Disability claim as stated in Ms. Medha Bharadwaj's letter but instead was 21 days after this date.**

Dr. Behrooz Tohidi suggested that I have office visits once per year. This treatment frequency was confirmed by Dr. James Helgager. During the time while Disability benefits were being paid to me, I saw Dr. Tohidi on an approximate one-year frequency. This is evidenced by the medical information submitted to CIGNA as:

- January 14, 2004 office notes for Mr. Nash's follow-up office visit to Dr. Tohidi
- January 16, 2004 CIGNA Follow-Up Medical Request Form signed by Dr. Tohidi
- January 16, 2004 CIGNA Physical Abilities Assessment Form signed by Dr. Tohidi
- January 4, 2005 office notes for Mr. Nash's follow-up office visit to Dr. Tohidi
- March 31, 2005 CIGNA Supplementary Claim Disability Benefits Form signed by Tohidi
- October 19, 2005 CIGNA Physical Abilities Assessment Form signed by Dr. Tohidi
- December 19, 2005 office notes for Mr. Nash's office visit to Dr. Stacey Lin
- January 4, 2006 office notes for Mr. Nash's office visit to Dr. Padilla

Cont.

7-18-06 cont	Cont **I saw Dr. Tohidi in January of 2004 and not again until January of 2005.** This timeline, and CIGNA's continuation of benefits without question during this period, shows CIGNA's acceptance, as Appropriate Care, of an office visit frequency of approximately once per year during the course of my long term Disability claim. In addition to these office visits, CIGNA was provided with completed and signed CIGNA Disability Forms each time one was requested in order to show my continued Disability. For CIGNA to now suggest after the fact that these timelines for updates of medical information are insufficient is random and capricious and in conflict with contract SLK-030024. The reasons provided by CIGNA for the denial of my claim and appeal show that CIGNA has attempted to change the requirement for frequency of office visits and documentation of my Disability without notification to me. This is despite that the once per year frequency meets the contract requirements of Appropriate Care. Ms. Bharadwaj's statement that, "... the medical records in the file do not support severity of any condition as of November 30, 2005 that would support limitations and/or restrictions precluding you from performing your occupation," shows that denial was based on lack of evidence **on a specific date**. This is stated by CIGNA despite multiple medical record entries in my file both prior to and immediately following my termination of benefits. The rationale that specific information be required on specific dates places the requirement upon me to have obtained medical evidence on specific dates - without notice or foresight - to provide to CIGNA should it decide to deny benefits at any time. This is clearly not a requirement in contract SLK-030024. To dismiss medical evidence, including that which was provided as shown in the timeline above, due to it not having been gathered on a specific date is both arbitrary and capricious. The medical information was provided in a timely manner and at relevant times in relation to both the date of denial of benefits and the definition of Appropriate Care in accordance with contract SLK-030024. Ms. Bharadwaj's letter continues with, "Disability is determined by medically supported limitations and restrictions which would preclude you from performing the duties of your light occupation as a Vice President." This statement is consistent with the evidence in my administrative record. My doctors have provided CIGNA with medically supported limitations and restrictions each and every time CIGNA requested such information and documented this on CIGNA forms that have been completed and signed by my attending physicians. These forms have been completed and provided to CIGNA both prior to and after the date benefits were denied. Ms. Bharadwaj's letter continues with, "While the documentation on file described your conditions, it does not provide clinical findings that would support the severity of your condition and functional deficits that would preclude you from performing your occupation ...." This statement is contrary to the evidence in my administrative record as my file is complete with such clinical findings that specifically support my functional deficits. **The primary single deficit is lack of ample range of motion in my left hip to sit in an upright position** as required by my own occupation or any occupation. This information is documented and the deficit supported in each and every instance of medical information provided throughout the history of my claim. Cont	cont

7-18-06	Cont. Ms. Bharadwaj's letter states that. "... our medical director reviewed all the medical information contained in your claim file." However, there is no evidence that the CIGNA medical director reviewed my entire file, which contains enormous amounts of relevant medical information not found in office notes. Specifically, such medical information includes Exhibit 1 of my appeal, my sworn affidavit, providing relevant, vital medical information that should be used by any medical personnel reviewing my medical situation, and Exhibit 27 of my appeal, the analysis of the video surveillance that was taken just prior to termination of my benefits, showing the obvious limited range of motion of my left hip. To deny my claim implying that my medical condition and my Disability changed during the period between my various physician office visits is without medical merit. **There exists no evidence that suggests that I was not Disabled on November 30, 2005.** There exists overwhelming evidence that I was in fact Disabled on, before and after November 30, 2005 and remain Disabled today. Based on the relevant errors of fact in Ms. Bharadwaj's denial letter, I request that you reevaluate my appeal and reinstate my long term Disability benefits. I have exhausted my required steps under ERISA law prior to bringing legal action against CIGNA. I believe the denial of my claim for benefits to be in violation of contract SLK-030024, California State Insurance law, and Federal ERISA law. Please contact me at 760-518-4823 if you have questions or would like to discuss a resolution		TN_2APP1056 - TN_2APP1058
7-24-06		Ltr: Nash to Alan Ey You were recently contracted by CIGNA to provide an Occupational Review of my former position as the Vice President, Business Development of Morpho Technologies. Attached to this fax you will find information on the medical condition of me, Mr. Todd M. Nash. The report you provided CIGNA is also attached. You were provided with two pieces of information including a Job Description contained in a letter dated 10/9/03 and DOT printouts for Financial Planner; Research and Development; and Vice President. What you were not provided with is any information on my condition. **I have severe osteoarthritis of my left hip that precludes me from bending my left leg past approximately 40 to 70 degrees. This prevents me from sitting in an upright position. I think that you would agree that it is a fundamental requirement for any job position that you have reviewed for my file that I must be able to sit in an upright position and do so for extended periods while working and traveling.** **CIGNA continues to vaguely document my past job description as light sedentary work while ignoring the fundamental requirement for sitting** since it is not specifically detailed in the DOT printout but is included in the O*NET Report 11-1011.02 - Private Sector Executives which, although included with my appeal, was not provided to you by CIGNA. Cont.	TN_2APP1044 - TN_2APP1045

7-24-06	Cont I urge you, based on the ethic code requirements of your professional designation as a CRC as administered by The Commission on Rehabilitation Counselor Certification and as a CDMS administered by The Certification of Disability Management Specialists Commission, to act upon the information contained in this fax and inform CIGNA of applicable changes in your report based upon this new information. I too am a member of a professional organization that requires and relies on the high ethical standards of its members and I therefore understand the importance of what I am asking you to do. Specifically I ask that you increase the accuracy of your report by adding that the occupations reviewed require sitting in an upright position for extended periods as a fundamental requirement. My case with CIGNA will likely move to State and Federal Court unless it can be first resolved by other means. Your report provided to CIGNA and this letter will become part of that case should it move to court. Mr. Ey, I realize that this might be a unique situation for you. I urge you to make the ethically correct choice and increase the accuracy of your report by adding the requirement for sitting. I am not asking you to make any other judgment about my case but to simply add some missing detail. I have provided an excerpt from the O*NET report and a brief portion of my medical information. I am happy to provide you with complete copies of both but I did not want to be to burdensome on your fax machine. I ask that you please notify me of your action in this matter. You may contact me via phone at 760-518-4823, via fax at 760-729-6823, or via email at tmnash@sbcglobal.net.	TN_2APP1044 - TN_2APP1045
7-24-06	07/24/06 4:30 (Including this sheet) ; 8 (860) 731-3049 TO Mededha BharadWaj From Alan Ey, Vocational Rehabilitation Counselor Comments RE: Todd Nash [appeal) Medha, Attached please find correspondence received from Mr. Nash concerning his appeal. I called Mr. Nash and had a conversation with him on 7/24/06, The extent of that conversation was that **he expressed concern in that my review did not specify sitting requirements.** I pointed out to him that the last sentence on page two states that the essential jab functions do not exceed the sedentary exertional level. **Inherent in the definition of sedentary is the physical demand of sitting for 6 of 8 hours.** Thus, in the course of his duties as a vice president there would be a significant amount of sitting. Indeed, the air travel requirement would require significant sitting. Please advise if there are any questions. Alan	TN_2APP1042

7-28-06	Ltr: Nash to Karol Johnson & Medha Bharadwaj I am in receipt of a letter dated July 21, 2006 from Ms. Medha Bharadwaj in which she writes expressing conflicting information in my letter to you date July 18, 2006. As I stated in my July 18, 2006 letter, the letter is not an appeal as provided under the terms of contract SLK-030024 or ERISA rules nor under any voluntary appeals process offered by CIGNA. My July 18, 2006 letter is correspondence to CIGNA identifying specific errors by CIGNA in evaluating my original appeal. I am requesting that CIGNA perform an examination of its original appeal review to correct these errors. I am not submitting additional medical information at this time and therefore I am not requesting a voluntary appeal at this time. The following highlight the errors made by CIGNA during the appeal process: 1. CIGNA has incorrectly ignored the portion of contract SLK-030024 that defines Disability as "unable to earn 80% or more of your Indexed Covered Earnings." I have successfully met this requirement, solely due to my illness, of the contract but CIGNA continues only to state that I am not "totally disabled." 2. CIGNA has incorrectly identified a claim termination date of November 30, 2005 when the claim was still open through December 13, 2005. 3. CIGNA has incorrectly stated the age of the medical information as being "several weeks to several months" old. 4. CIGNA's medical director incorrectly states, "No notes are provided from physician, PT, or anyone else that give info of deficits on or around denial date." My appeal provides evidence from three physicians each providing such deficit information around the denial date as follows: a. Dr. Tohidi provided the CIGNA Physical Abilities Assessment Form signed on October 19, 2005 stating specific deficits and limitations. b. Dr. Lin's office notes from 6 days after claim termination clearly state that I had, "decreased range of motion, only about 5 degrees to lift his knees up off the table." c. Dr. Padilla's office notes from 21 days after claim termination clearly state that I had, "forward flexion approximately 45 degrees". Each of these physicians has provided CIGNA with the deficit of my inability to move my leg into a seated position as evidenced by my limited range of motion. 5. Ms. Bharadwaj's letter incorrectly states, "While the documentation on file described your conditions, it does not provide clinical findings that would support the severity of your condition and functional deficits that would preclude you from performing your occupation ...." Items a, b, and c in number 4 above specifically provide evidence of my condition and functional deficits that preclude me from performing my occupation, any occupation, or earning 80 percent of my indexed covered earnings. Cont	TN_2APP1051 - TN_2APP1053

7-28-06 cont	Cont 6. CIGNA erred by arbitrarily dismissing medical records that are 55 days prior and just 6 and 21 days after the termination of my claim, stating that it does not provide evidence of continuous Disability as of November 30, 2005. CIGNA has erred by establishing a criteria for gathering medical information that is not a requirement of contract SLK-030024. The only way to meet CIGNA's requirements, that have been wrongly established ex post facto, would have been for me to have specifically gathered medical information on November 30, 2005 that met specific yet unspecified requirements of CIGNA. This is not a requirement under contract SLK-030024 or under ERISA. 7. CIGNA has accepted as Appropriate Care during the course of my claim an office visit frequency of once per year and has now erred by stating ex post facto that this is insufficient. 8. CIGNA erred by ignoring that Sedentary is defined as: Characterized by or requiring much sitting. In his Occupational Review, Mr. Alan L. Ey correctly identified my former position as having sedentary requirements. Mr. Ey has since clarified his Occupational Review of my former position to explicitly define sedentary as the requirement to sit for six of eight hours during a normal workday. Mr. Ey made this clear to me in a phone conversation on Monday, July 24, 2006 at approximately 3:22pm PDT and should have by now added this clarification to my administrative record at CIGNA. My deficits and restrictions for sitting are clearly detailed throughout my administrative record as well as evidenced in the surveillance video and documented in the video surveillance analysis included with my appeal. The deficits and restrictions are evidenced at relevant dates at and around the termination of my claim. Each of these errors by CIGNA has directly harmed my appeal, my appeal process, and me. **I am requesting that CIGNA address, in a response to me, these errors in its review of the original appeal.** At this time, I am not submitting new medical information and therefore not requesting a voluntary appeal. If CIGNA still believes there to be a conflict between: 1. my requesting that CIGNA review and respond to me regarding its errors in processing the existing information in my appeal; and 2. me stating that this is not a voluntary appeal since I am not providing new medical information, then I ask that you or a CIGNA representative call me so that we can discuss this perceived conflict. Based on the errors in processing my appeal I request that you reevaluate my appeal and reinstate my long term Disability benefits. Please contact me at 760-518-4823 if you have questions or would like to discuss a resolution.	TN_2APP1051 - TN_2APP1053

8/10/06	Stacey Lin MD updated examination	awaiting receipt of med. records
8/19/2006	Vicodin, prescription refill	
10-23-06	Dr. Tohidi: office notes Note for Todd Nash on 10/23/2006 - Chart 16959 **Subjective**: This 42 year old male returns further evaluation of left hip pain. I have seen and treated Mr. Nash for severe osteoarthritis of the left hip since 2003. I have seen him at least six (6) times during the this period, to date, am obviously very familiar with his testing, his clinical presentation, and significantly limiting symptomatology. He has followed my medical recommendations and seen me at intervals I have recommended. The condition of his hip was advanced at the time of initial evaluation. I provided him with information regarding various treatments including pain management, activity modifications, hip replacement, their types, complications, risks, limitations and prosthetic life expectancy. For the time being, because of his age, he chose to live with this condition and attempt to manage his symptomatology and marked limitations by significant activity restrictions and limitations. By "activity", I am including limitations in exertional and nonexertional "activity" such as his inability to sustain prolonged positional sitting or standing, At some time in his future, he will undoubtedly need to revisit the appropriate future timing of a total hip replacement, but for the time being, I concur with his decision. Mr. Nash is allergic to aspirin. I have prescribed him Vicodin 5/500 to relieve pain. I have advised him that the side effects of this narcotic pain medication including probable reduction of cognitive ability and ability to concentrate. I have advised him he should not operate an automobile while taking this medication. Mr. Nash has a significant functional disability due to existing marked stiffness and pain with activity. This is noticeable in my examinations of him, in his movement, in the consistency of his reports that I take during each history and follow up visit, and in the pain behavior that I personally witness. The symptoms and significant limitations of Mr. Nash are those that I would expect given his hip illness and they are fully consistent with other patients I see with similar level of hip disease. Based on my expertise in this specialty, it is my medical opinion that Mr. Nash has demonstrated no malingering during my examinations and interviews of him, and that his complaints, symptoms and signs, are fully consistent with the level of disease he has and with other patients I see who are in the same condition and the same stage of their disease. In August 2003, I measured Mr. Nash's range of motion in his left hip as being 0 degrees of external rotation, about 30 degrees of internal rotation, 25 degrees of abduction, 15 degrees of adduction, and 50 degrees of flexion. (Estimates of average normal limits of hip joint motion are 45 degrees of external rotation, 45 degrees o f internal rotation, 45 degrees of abduction, 30 degrees of adduction and 120 degrees of flexion.) These measurements objectively show that Mr. Nash is incapable of flexing his left hip into an upright sitting position. This inability to sit upright remains true today. I have reviewed the medical records provided by Dr. Stacey Lin, dated December 20,2005, Dr. Patrick Padilla dated January 04,2006 and by Dr. James Helgager, dated February 9,2006 and April 20,2006, including x-rays taken on January 4, 2006. Continued...	TN_2APP Ex 0008 - 0010

cont

The January 4,2006 x-rays, and the observations reported by Dr, Lin's, Dr, Padilla's and Dr. Helgager's notes generally concur with my assessment of Mr. Nash and provide further evidence that Mr. Nash's illness has progressed, as expected, in a degenerative way and shows no sign of improvement since Mr. Nash's office visit with me in January 2005. Due to the progressive degenerative nature of Mr. Nash's illness, the severity of hip illness has not and could not have improved in the continuous period from September 2003 to January 2006 and beyond. Additionally, the resulting limitations and restrictions associated with his illness have not been and could not have been lifted in the continuous period from September 2003 to January 2006 and beyond and certainly not on November 30,2005 or on December 13,2005. This will remain true until such time as Mr. Nash has undergone total hip replacement and rehabilitated, Of course, this is not a guarantee that even then he will not continue to have limitations and his activities be restricted. It may also be associated with discomfort prolonged positions and activities. However, it is premature to address that at present.

I have added the underlining in the above passage to emphasize my professional medical opinion because I understand from reading the letter from CIGNA dated 3uly 10, 2006 to Mr. Nash that CIGNA has apparently reasoned that since Mr. Nash was not seen during a specific period that he somehow was not disabled or limited and restricted at that time. This rationale is medically preposterous. The progressive degenerative nature of Mr. Nash's illness combined with the evaluations of Dr. Lin, Dr. Padilla, Dr. Helgager, and myself, provide clinical evidence of the continuous severity of Mr. Nash's illness and resulting functional deficits from September 2003 to the present. Specifically the severity of Mr. Nash's illness and resulting functional deficits preclude him from performing the duties of his former occupation as documented in his medical records or any occupation that I can envision. Specifically, in addition to other limitations and restrictions, Mr. Nash is now and has been, continuously from September 2003 to the present, incapable of sitting upright as required by even sedentary work. Mr. Nash's hip condition in January 2005 would be either the same or worse both clinically and radiographically, in November 2005 and January 2006. Today I have examined Mr. Nash, including x-rays taken in 2003 and January 2006 and the degeneration of his hip has worsened since 2003. Due to the degenerative nature of Mr. Nash's illness, routine x-rays and detailed range of motion measurements are not necessary for treatment of his condition unless condition significantly worsens or until such time the patient is preparing for total hip replacement. Additionally, Magnetic Resonance Imaging (MRI) is not a necessary aspect of treating Mr. Nash's illness.

PFSH: Allergies: Patient admits allergies to aspirin resulting in unknown reaction.

Objective: The physical exam is updated as follows.

Patient is a pleasant, 42 year old male in no apparent distress who looks his given age, is well- developed and nourished with good attention to hygiene and body habitus.
Oriented to person, place and time.
Mood and affect normal, appropriate to situation.
Gait and station examination reveals antalgic gait left. ROM o f left hip is as follows: sitting 45 degrees, flexion 45 degrees, external rotation 0 degrees, internal rotation 0 degrees, abduction 20 degrees, adduction 0 degrees.

Test & X-Ray Results: Joint - left hip x-ray shows severe progressive osteoarthritis.

Continued...

10-23-06	Dr. Tohidi: office notes continued **Assessment:** OA hip left moderate to severe. It is my medical opinion that the appropriate care and treatment for Mr. Nash has been and continues to be to manage his illness by activity modification and pain management while postponing total hip replacement for as long as Mr. Nash can tolerate his condition. This medical recommendation comes after multiple examinations including x-rays, a cortisone injection that has shown to provide neither increased capacity nor sustainable reduction in pain, and the exclusion of of non-steroidal anti-inflammatories due to Mr. Nash's aspirin allergy. Due to the progressive degenerative nature of Mr. Nash's illness, providing the appropriate level of care requires that I, or other qualified physician, see him no more than once per year or more frequently if, in Mr. Nash's own opinion, his personal status changes such that he desires to pursue total hip replacement surgery. Prior to today, I last saw Mr. Nash in January 2005. The severity of his condition over this prod remains the same to moderately worse. **Plan:** Activity modifications are as follows; Sitting - limited to sitting in a reclined position. Restricted to no more than 30 minutes at a time with 60 minute recumbency in between occurrences. Standing restricted to periods no greater than 30 minutes at a time with 60 minute recumbency in between occurrences. Reaching overhead - restricted to periods no greater than 30 minutes at a time with a 60 minute recumbency in between occurrences. Reaching at desk level - restricted to periods no greater than 30 minutes at a time with 60 minute recumbency in between occurrences. The following activities are restricted to no activity of this type: forward bent sitting, forward bent standing, climbing, balancing, crawling, crouching, stooping, bending to 90 degrees or greater, reaching below waist, use of lower extremities for foot control. The limitations and restrictions resulting from Mr. Nash's illness prohibit him from safely performing many activities. The above limitations and restrictions have been placed upon him since September 2003 and have remained in place, without suspension, to the present. These restrictions will remain in place until Mr. Nash has a total hip replacement surgery and has been adequately rehabilitated. These restrictions are placed upon Mr. Nash's activities to assist in managing his pain, minimizing additional degradation of his hip joint and avoiding further illness or injury to him. Vicodin 5/500 has been prescribed for pain relief. Mr. Nash has been advised that the side effects of this medication include probable reduction of cognitive ability and ability to concentrate. I have advised him that he should not operate an automobile while taking this medication. Behrooz Tohidi, MD	continued TN_2APP_Ex00 08 through TN_2APP_Ex00 10

10-23-06	Dr. Tohidi: Letter (Medical opinions) 119B Victory Drive Swainsboro, GA 30401 Fax: (478) 237-4778 (478) 237-7676 I am forwarding this letter on behalf of Mr. Todd Nash whom I have seen and treated since 2003 for severe osteoarthritis of the left hip. I have seen him at least six (6) times during this period, to date, and am obviously very familiar with his testing, his clinical presentation, and significantly limiting symptomatology. He has followed my medical recommendations and seen me at the intervals I have recommended. The condition of his hip was advanced at the time of initial evaluation. I provided him with information regarding various treatments including pain management, activity modification, hip replacement, their types, complications, risks, limitations, and prosthetic life expectancy. For the time being, because of his age, he chose to live with this condition and attempt to manage his symptomatology and rather marked limitations by significant activity restrictions and limitations. By "activity," I am including limitations in exertional and nonexertional "activity" such as his inability to sustain prolonged positional sitting or standing. At some point in his future, he will undoubtedly need to revisit the appropriate future timing of a total hip replacement, but for the time being, I concur with his decision. Mr. Nash is allergic to aspirin. I have prescribed him Vicodin 5/500 to relieve pain. I have advised him that the side affects of this narcotic pain medication include probable reduction of cognitive ability and ability to concentrate. I have advised him that he should not operate an automobile while taking this medication. It is my medical opinion that appropriate care and treatment for Mr. Nash has been and continues to be to manage his illness by activity modification and pain management while postponing total hip replacement for as long as Mr. Nash can tolerate his condition. This medical recommendation comes after multiple examinations including x-rays, a cortisone injection that has shown to provide neither increased capacity nor sustainable reduction in pain, and the exclusion of non-steroidal anti-inflammatories due to Mr, Nash's aspirin allergy. Due to the progressive degenerative nature of Mr. Nash's illness, providing the appropriate level of care requires that I, or other qualified physician, see him no more that once per year or more frequently if, in Mr. Nash's own opinion, his personal status changes such that he desires to pursue total hip replacement surgery. Prior to today, October 23,2006, I last saw Mr. Nash in January 2005. The severity of his condition over this period remains the same to moderately worse. Mr. Nash has a significant functional disability due to existing marked stiffness and pain with activity. This is noticeable in my examinations of him, in his movement, in the consistency of his reports that I take during each history and follow up visit, and in the pain behavior that I personally witness. The symptoms and significant limitations of Mr. Nash are those that I would expect given his hip illness and they are fully consistent with other patients I see with a similar level of hip disease. Based on my expertise in this specialty, it is my medical opinion that Mr. Nash has demonstrated no malingering during my examinations and interviews of him, and that his complaints, symptoms and signs, are fully consistent with the level of disease he has and with other patients I see who are in the same condition and at the same stage of their disease. continued....	new for appeal TN_2APP_Ex0 001 - 0004

10-23-06	Tohidi cont. In August 2003, I measured Mr. Nash's range of motion in his left hip as being 0 degrees of external rotation, about 30 degrees of internal rotation, 25 dg of abduction, 15 degrees of adduction, and 50 degrees of flexion. (Estimates of average normal limits of hip joint motion are 45 degrees of external rotation, 45 degrees of internal rotation, 45 degrees of abduction, 30 degrees of adduction, and 120 degrees of flexion.) These measurements objectively show that Mr. Nash is incapable of flexing his left hip into an upright sitting position. This inability to sit upright remains true today. I have reviewed the medical records provided by Dr. Stacey Lin, dated December 20, 2005, Dr. Patrick Padilla dated January 04,2006 and by Dr. James Helgager, dated February 9, 2006 and April 20,2006, including x-rays taken on January 4,2006. The January 4,2006 x-rays, and the observations reported in Dr. Lin's, Dr. Padilla's and Dr. Helgager's notes generally concur with my assessment of Mr. Nash and provide further evidence that Mr. Nash's illness has progressed, as expected, in a degenerative way and shows no sign of improvement since Mr.Nash's office visit with me in January 2005. Due to the progressive degenerative nature of Mr. Nash's illness, the severity of his illness has not and could not have improved in the continuous period from September 2003 to January 2006 and beyond. Additionally, the resulting limitations and restrictions associated with his illness have not been and could not have been lifted in the continuous period from September 2003 to January 2006 and beyond and certainly not on November 30,2005 or on December 13, 2005. This will remain true until such time as Mr. Nash has undergone total hip replacement and rehabilitated. Of course, this is not a guarantee that even then he will not continue to have limitations and his activities be restricted. It may also be associated with discomfort with prolonged positions and activities. However, it is premature to address that at present. I have added the underlining in the above passage to emphasize my professional medical opinion because I understand from reading the letter from CIGNA dated July 10,2006 to Mr. Nash that CIGNA has apparently reasoned that since Mr. Nash was not seen during a specific period that he somehow was not disabled or limited and restricted at that time. This rationale is medically preposterous. The progressive degenerative nature of Mr. Nash's illness combined with the evaluations of Dr. Lin, Dr. Padilla, Dr. Helgager, and myself, provide clinical evidence of the continuous severity of Mr. Nash's illness and resulting functional deficits from September 2003 to the present. Specifically the severity of Mr. Nash's illness and resulting functional deficits preclude him from performing the duties of his former occupation as documented in his medical records or of any occupation that I can envision. Specifically, in addition to other limitations and restrictions, Mr. Nash is now and has been, continuously from September 2003 to the present, incapable of sitting upright as required by even sedentary work. Mr. Nash's hip condition in January 2005 would be either the same or worse both clinically and radiographically, in November 2005 and January of 2006. Today I have examined Mr. Nash, including x-rays taken in 2003 and January 2006 and the degeneration of his hip has worsened since 2003. Due to the degenerative nature of Mr. Nash's illness, routine x-rays and detailed range of motion measurements are not necessary for treatment of his condition unless his condition significantly worsens or until such time the patient is preparing for total hip replacement. Additionally, Magnetic Resonance Imaging (MRI) is not a necessary aspect of treating Mr. Nash's illness. Cont.	

10-23-06	It is my medical opinion based on my examinations and follow up of Mr. Nash that his sitting - limited to sitting in a reclined position. Restricted to no greater than 30 minutes forward bent sitting - restricted to no activity of this type; standing - restricted to periods no greater than 30 minutes at a time with 60 minute forward bent standing - restricted to no activity of this type; climbing - restricted to no activity of this type; balancing - restricted to no activity of this type; crawling - restricted to no activity of this type; crouching - restricted to no activity of this type; stooping - restricted to no activity of this type; bending to 90 degrees or greater - restricted to no activity of this type; reaching overhead -- restricted to periods no greater than 30 minutes at a time with 60 minute recumbency in between occurrences; reaching at desk level - restricted to periods no greater than 30 minutes at a time with 60 minute recumbency in between occurrences; reaching below waist - restricted to no activity of this type; use of lower extremities for foot control - restricted to no activity of this type; restrictions and limitations are: at a time with 60 minute recumbency in between occurrences; recumbency in between occurrences; The limitations and restrictions resulting from Mr. Nash's illness prohibit him from safely performing many activities. The above limitations and restrictions have been placed upon him since September of 2003 and have remained in place, without suspension, to the present. These restrictions will remain in place until Mr. Nash has a total hip replacement surgery and has been adequately rehabilitated. These restrictions are placed upon Mr. Nash's activities to assist in managing his pain, minimizing additional degradation of his hip joint, and avoiding further illness or injury to him. In the letters from CIGNA dated December 13, 2005 and July 10,2006, which I have read, desired specific clinical or medical information or clarifications have not been identified to assist CIGNA in understanding Mr. Nash's quite disabling condition. Therefore, I have provided what in my own experience I though might be helpful. That said however, if you should need further information, do not hesitate to write, asking any questions you wish. I will make every effort to provide any further written details you need. I do require written questions to avoid misunderstanding or inaccuracy, and of course a later record for Mr. Nash's patient chart. End	

10-23-06	**Ltr: Dr. Tohidi** To Whom It May Concern: (medical assessment of video excerpts) I am forwarding this letter on behalf of Mr. Todd Nash whom I have seen and treated since August 2003 for severe osteoarthritis of the left hip. I have watched a surveillance video of Mr. Nash. The video was provided to me by him on four CDs labeled as: "PhotoFax, Claimant: Todd Nash, Date of Surveillance Part x of 4 10/25-29/05, PhotoFax Surveillance Corporation, 800-659-935 1 , www.Dhotofax.net" I have copied the label information so that you will know what I viewed, The video runs for 4 hours. Mr. Nash told me that he got this video from CIGNA and he has asked me to look at it and these are my observations. The video lasted about 240 minutes or 4 hours and was taken over 5 days. The video does not show continuous activities. By watching the video, I can't tell if the video was obtained by starting and stopping the camera or if it was continuous footage that was edited later. The video shows Mr. Nash walking with a modified gait and deflecting his left leg due to the marked stiffness in his left hip. A few of the many pieces of the video that show the patient has marked limitations include: Tuesday, October 25,2005 8:53 am - Patient hyper extending his left leg at the knee joint and bending his back to accommodate the marked stiffness in his left hip 11:13 am - Patient walking with a modified gait consistent with severe osteoarthritis of the left hip	Tohidi ltr p 1
10-23-06 cont	Todihi re surveillance cont. Wednesday, October 26,2005 9:33 am - Patient walking with a modified gait consistent with severe osteoarthritis of the left hip 2:47 pm - Patient shown four times within this minute extending his left leg behind him to accommodate the marked stiffness in his left hip 3:OO pm - Patient extending his left leg behind him to accommodate the marked stiffness in his left hip Thursday, October 27,2005 7:32 am - Patient extending his left leg behind him to accommodate the marked stiffness in his left hip 7:49 am - Patient extending his left leg behind him to accommodate the marked stiffness in his left hip 9:45 am - Patient walking with a modified gait consistent with severe osteoarthritis of the left hip 12:02 pm and 12:06 pm - Patient sliding a bin while walking with a modified gait consistent with severe osteoarthritis of the left hip 2: 15 pm - The video shows Mr. Nash walking with a modified gait consistent with severe osteoarthritis of the left hip Fridav, October 28,2005 1 : 17 prn - Patient walking with a modified gait consistent with severe osteoarthritis of the left hip continued...	Tohidi ltr p.1 Ltr p. 2

10-23-06 cont	Tohidi surveillance comments continued Saturday, October 28,2005 9:33 am - Patient lifting a child without bending at the waist. This improper lifting form is consistent with severe osteoarthritis of the hip and is due to the marked stiffness in the afflicted hip joint. 10:29 am - Patient walking with a modified gait consistent with severe osteoarthritis of the left hip 10:48 and 1050 am - Patient extending his left leg behind him to accommodate the marked stiffness in his left hip. 12:41 pm - Patient walking with a modified gait consistent with severe osteoarthritis of the left hip The video contains many occurrences of the patient moving with very marked stiffness. The items above are only a few of the many that I observed in the video. I have described these examples because even persons not familiar with the mechanics of diseased hips could observe his limitations. This patient has significant limitations with sitting. The video does not show the patient sitting except for a few excerpts getting into his car and one clip lasting only a few seconds of him sitting at a table. Also, the patient has limitations with standing. When the patient is shown standing for a few minutes he is often shown leaning against a tree, a wall, or other crutch taking weight off his left leg. The patient is not shown positioning his left hip in a way that is inconsistent with his disease and resulting limitations. The poor quality of the video does not clearly show the patients facial expressions and often is taken from behind. This does not allow me to see the indication of pain on the patient's face.	Tohidi ltr p.2 Tohidi ltr p.3
10-23-06 cont.	(Tohidi surveillance comments continued) I have also read the PliotoFax surveillance report that was on the CD with the video. In my opinion, this report was either prepared by an inexperience person and/or a person using descriptions intended to describe the patient's movement in an inappropriate way. The descriptions used do not mention what is clearly seen in the video. Because it was so obviously missed so many times, it might be an intentional omission to paint the patient in a good light. The descriptions are inaccurate and at best misleading. The 4 hours of video over 5 days is a small amount of time compared to what I consider to be a normal workweek. The video does not show the patient engaged in the sedentary activities of his former employment, specifically sitting for extended times. However, the video does clearly show that the patient is incapable of moving his left leg into an upright-seated position. If you should need further information about my observations of this video and report and how they relate to the patient's medical condition, do not hesitate to write, asking any questions you wish. I will make every effort to provide any further written details you need. I do require written questions to avoid misunderstanding or inaccuracy, and of course a later record for Mr, Nash's patient chart.	Tohidi ltr p.3
12/20/06	Vicodin, prescription refill	

TN_2APP1322
-1323

CV of BEHROOZ TOHIDI, M,D,
119B VICTORY DRIVE
SWAINSBORO, GA 30401
478-237-7676 FAX: 478-237-4778
behrooztohidi@sbcglobal.net www .behrooztohidimd.com

7/79-7/83 Residency: Emory University School of Medicine and Affiliated Hospitals, Department of Orthopaedic Surgery, Atlanta, Georgia

7/77-6/79 Internship: University of Rochester Medical Center, General Surgery, Rochester, New York

7/67-6/75 Shiraz: (Pahlavi) School of Medicine, Shiraz, Iran-including one year rotating internship

EXPERIENCE

10/05 - Present: Emanuel Medical Center, Swainsboro, Georgia, General Orthopaedic with emphasis on Joint Replacement and Arthroscopic Surgery

1/89-9/05: San Diego Joint Replacement Medical Center, Encinitas, California, General Orthopaedic with emphasis on Joint Replacement and Arthroscopic Surgery

10/83-12/88: Mission Park Clinic, Oceanside, California, General Orthopaedic with emphasis on Joint Replacement and Arthroscopic Surgery

6/83-8/83: Elective course with Dr. John C, Garrett, Atlanta, Georgia: Sports Medicine with emphasis on Arthroscopic Surgery

7/75-6/77: Iranian Army, General Practice

"Thompson Prosthesis, A Five Year Review" presented at the Kelly Society, Atlanta, Georgia, 1980

Closing Wedge Values High Tibial Osteotomy -Correlation of Patient's Subjective Outcome with Preoperative Assessment. Prepublication

MEDICAL LICENSES
California, Georgia, New York

MEMBERSHIPS
American Academy of Orthopaedic Surgeons,
California Orthopaedic Association,
Western Orthopaedic Association

HOSPITALS
Emmuel Medical Center, Swainsboro, Georgia
Scripps Memorial Hospital, La Jolla, California

APPOINTMENTS
Chief, Division of Orthopaedic Surgery, Tri-City Medical Center, 86-87,88-89,99-00, 00-01
Diplomat, American Board of Orthopaedic Surgery, 7/90, applied for recertification exam of 2007
Fellow, American Academy of Orthopaedic Surgeons, 1992

end

EXHIBIT H

EXHIBIT H

Karen I. Nichols
Appeals Claim Manager
CIGNA Disability Management Solutions

CIGNA Group Insurance
Life · Accident · Disability

12225 Greenville Ave
Ste. 1000 LB 179
Dallas, TX 75243-9384
Telephone 800-352-0611X1249
Facsimile 860-731-3211

July 18, 2007

RECEIVED
JUL 23 '07
MMPP&H

SUSAN L HORNER
ATTORNEY AT LAW
501 WEST BROADWAY STE 700
SAN DIEGO CA 92101-3563

Re:	Claimant:	Todd Nash
	LOB :	Long Term Disability
	Policy #:	SLK 30024
	Policyholder:	Administaff
	Company:	Life Insurance Company of North America

Dear Ms. Horner:

We have completed our review of your client's appeal for Long Term Disability benefits under the above captioned Plan. This letter will serve to advise you that after our review of Mr. Nash's file we are affirming our previous denials dated December 13, 2005 and July 10, 2006 (copies enclosed). Please refer to those letters and to the specific policy definitions below for specific information regarding your client's denial.

The definition of disability under the above Plan is defined as follows:

> "The Employee is considered Disabled if, solely because of Injury or Sickness, he or she is either:
> 1. unable to perform all the material duties of his or her Regular Occupation or a Qualified Alternative; or
> 2. unable to earn 80% or more of his or her Indexed Covered Earnings.
>
> After Disability has lasted 30 months, the Employee is considered Disabled if, solely due to Injury or Sickness, he or she is either:

EXHIBIT H -1

"CIGNA" and "CIGNA Group Insurance" are registered service marks and refer to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Life Insurance Company of North America, CIGNA Life Insurance Company of New York, and Connecticut General Life Insurance Company.

1. unable to perform all the material duties of any occupation for which he or she is, or may reasonably become, qualified based on education, training or experience; or
2. unable to earn 80% or more of his or her Indexed Covered Earnings."

Termination of Disability Benefits:

Benefits will end on the earliest of the following dates:

...... 2. the date we determine you are not disabled.

We will require continued proof of your Disability for benefits to continue.

We based our decision to deny your client's claim for benefits after November 30, 2005, on Plan language and all of the documents contained in your client's claim file, viewed as a whole.

For the purpose of this review we will be evaluating whether or not Nr. Nash retained the functional capacity to perform his occupation as explained in the definition of disability above. The records on our file indicate that Mr. Nash's occupation is that of Vice-President of Business Development. The information in your client's file indicates he stopped working September 29, 2003 and benefits were paid through November 30, 2005. Your client's disability claim was denied additional benefits as medical information did not support an impairment severe enough to preclude him from performing the material duties of his Regular Occupation.

We reviewed new and existing information contained on file. Since your client's decisions were based on medical information, his file was sent for review to an outside Peer Reviewer.

The records were reviewed and those records included, but are not limited to:

1. Intracorp Physician Review Instructions/Physician Referral Forms
2. Individual Patient's Authorization 10/6/03
3. Patient Questionnaire Form dated 9/26/03,
4. Cigna/Disability Management Solutions Medical Request Form dated 10/1/03, 1/16/04,
5. Insurance Claim Forms 2/9/04, 3/11/05, 9/22/05,
6. Employment History
7. Occupational Description 10/28/05
8. Occupational Requirements 10/28/04, 2/23/04,
9. Surveillance Tape Indemnification Agreement dated 6//25/07
10. Appeal File Review dated 6/30/06

11. Progress Notes dated 12/31/97 (handwritten), two pages dates not legible, 7/18/03, 9/25/03, 9/26/03, 11/03
12. X-ray Report dated 2/3/98; Left Hip
13. Clinic Note dated 4/27/98; Leonard R. Ozerkis, MD
14. X-ray Report dated 3/2/01; Chest two views
15. Quest Diagnostics/Lab Results (3 pages; date not legible)
16. Unilab/Lab Results dated 6/5/02, 10/3/03, 10/13/03
17. Sharp Urgent Care Center/Clinic Notes (2 pages); Chief Complaint Skin Rash (not dated)
18. Sharp Urgent Care/Urgent Care After Care Instruction Sheet (date not legible)
19. Tri City Medical Center X-ray Report dated 7/18/03, Right Hip
20. Clinic Notes dated 8/8/03, 8/14/03, 9/5/03, 1/14/04, 1/4/05, 10/23/06 ; Behrooz Tohidl, MD
21. Tri City Medical Center X-ray Report dated 8/8/03; AP Standing Hips
22. Carlsbad Village Family Practice/Chronological Record of Medical Care (handwritten, dates not legible)
23. Letter dated 11/10/03 to Mahyar Ajir, DO from Arthur B. Marshawsky, MD
24. Renal Ultrasound Report dated 11/14/03
25. Carlsbad Village Family Practice/Lab Results
26. Cigna/Disability Management Solutions Physical Abilities Assessment Forms dated 11/21/03, 10/19/05, 3/13/06, 3/22/06
27. Letter to Ms. Vandalyn Crayton from B. Tohidi, MD
28. Letter to Cigna from B. Tohidi, MD dated 1/14/04
29. Physical Ability Assessment dated 1/16/04
30. Letters to Mr. Nash dated 1/27/04, 1/30/04, 2/3/04, 12/21/05, 5/30/06, 7/10/06, 7/21/06, from Cigna
31. LTD Initial Telephone Contact Checklist dated 2/4/04
32. Vocational Rehabilitation Telephone Record dated 2/9/04
33. Prescription Form from Mahyar Ajir, DO dated 12/2/05
34. Letter dated 12/14/05 to Steve Eccles from Todd Nash
35. Document beginning with page 2 through page 6 dated 2/14/05 from Steve Eccles, ALHC Claim Manager
36. Sharp Mission Park Progress Note dated 12/19/05; Stacey Lin, MD
37. Handwritten Notes titled "Weight Loss"
38. Clinic Notes dated 1/4/06, 1/18/06, ; Stacey Lin, MD
39. Clinic Notes dated 2/9/06, 4/20/06; James A. Helgager, MD
40. Sharp Healthcare/Clinic Note dated 2/13/06; Stacey Lin, MD
41. Sharp Mission Park Medical Group: Patient Problem List; Patient Medication Record
42. Healthsouth Rehabilitation Centers/Physical Therapy Evaluation dated 3/21/06
43. Functional Capacity Evaluation dated 3/30/06 (15 pages)
44. Pacific Beach Physical Therapy Report dated 3/30/06
45. Tri-City Medical Center/XR Hip Injection Left dated 4/6/06
46. Appeal of Todd Nash (54 pages) dated 5/15/06 to Steve Eccles
47. General Affidavit Before Notary/640 Lines
48. Addendum A-1 to Appeal of Todd Nash dated 6/1/06 (5 pages)

49. Exhibits of Appeal of Mr. Todd Nash
50. Cigna/Disability Management Solutions Follow-Up Medical Request Form dated 1/16/04
51. List of X-rays
52. Medical Records (42 pages)
53. Letter with Attachments (Addendum A-1 and Exhibit 37) dated 6/1/06
54. Occupational Review 6/30/06 (two pages)
55. Appeal of Todd Mitchell Nash/Medical History
56. Letters dated 7/18/06, 7/28/06 to Ms. Karol Johnson and Ms. Medha Bhardadwaj from Todd Nash
57. Fax Cover Sheet dated 7/24/06 to Medha Bhardadwaj from Alan/Cigna
58. Letter to Alan L. By dated 7/24/06 from Todd Nash
59. Letter "To Whom it may Concern" dated 10/23/06 from Behrooz Tohidi, MD
60. Medication Sheets dated 5/10/06, 12/28/06/Sav-On Drugs
61. Cigna Current Case Plan Notes dated 3/6/04, 3/12/04, 2/25/04, 3/6/04, 10/1/03, 10/8/03, 10/14/03, 10/17/03, 10/30/03, 11/10/03, 11/17/03, 12/9/03, 1/27/04, 1/29/04, 2/16/04
62. Cigna/Claim Direction Staffing Forms dated 5/19/06, 11/28/05
63. Claim Staffing Session Form dated 9/26/03
64. Cigna/Incident Notes dated 10/8/03, 10/1/03, 10/11/03, 11/28/03, 12/8/03, 12/11/03, 12/10/03, 12/15/03, 1/9/04, 1/13/04
65. Task: Internal Resource Response dated 12/6/06 (3 pages)
66. Notes from Sharon Reeves
67. Appeal dated 7/10/06 to Ms. Bhardadwaj from Law Offices of Miller, Monson, Peshel, Polacek, & Hoshaw (50 pages)
68. Time Line Overview Form
69. Letter dated 2/28/07 to Ms. Bhardadwaj from Law Offices of Miller, Monson, Peshel, Polacek, & Hoshaw
70. Letter to Ms. Bhardadwaj dated 4/20/07 from Todd Nash
71. Sworn Affidavit/State of California dated 5/9/06
72. Note Re: Mr. Nash's handling of sheetrock
73. Sworn Affidavit/State of Montana dated 3/23/06
74. Resume of Todd Nash "continued" pages 2, 3, 4
75. Memo from Tom Eichenberg to Todd Nash dated 2/23/06 with Response from Mr. Nash dated 2/26/06
76. Memo from Todd Nash dated 2/23/06 to Tom
77. Social Security Administration Retirement, Survivors and Disability Insurance Form dated 6/5/04 (4 pages)

Our Peer Reviewer attempted to discuss Mr. Nash's case with Behrooz Tohidi, MD on July 11, 2007 and July 12, 2007. He was unavailable and messages were left with Dr. Tohidi, however, he did not receive a return call.

Our Reviewer discussed the medical information as follows:

- January 4, 2006 date Patrick Padilla, MD evaluated Mr. Nash and indicated that the physical examination revealed a leg length inequality of right greater than left of approximately 1cm. also noting significant tenderness to palpation about the hip.
- February 9, 2006 James Helgager, MD evaluated Mr. Nash indicated that anti-inflammatory had been tried but had not worked well and that Mr. Nash was unable to take aspirin and managing his condition with activity modification and Vicodin. Dr. Helgager indicated that Mr. Nash was not able to sit without reclining back because of the stiffness in his left hip. The assessment was advanced osteoarthritis left hip.
- February 13, 2006- Dr. Lin evaluated and according to the report of that day Mr. Nash leaned back to about 70 degrees. The assessment was severe left hip arthritis.
- March 22, 2006 report of Dr. Helgager indicated that Mr. Nash had severe left hip pain and was not capable of working and that limited range of motion prohibited him from upright sitting.
- March 30, 2006 Functional Capacity Evaluation (FCE) results concluded that Mr. Nash had deficits with respect to workplace tolerance in body mechanics due to left hip pain, muscular strength and endurance and range of motion
- October 23, 2006 Dr. Tohidi evaluation assessed osteoarthritis of the left hip, moderate to severe

Our Peer Reviewer also viewed the video surveillance of Mr. Nash's activities on 10/25, 10/26. 10/27, 10/28 and 10/29/2005. He is observed walking with a barely perceptible limp with respect to his left leg. He, on occasion, extends he left leg behind himself a he bends. He is observed driving a sport utility vehicle, pushing a cart in what appears to be a home improvement store, lifting what appears to be a 4 x 6 sheet of drywall out of a truck and over his head and ten carrying the sheet. He is seen to bend repeatedly, to more than 60 degrees at the waist. He is also observed sawing a piece of PVC pipe, carrying buckets in both hands, pushing a wheelbarrow, carrying assorted pieces of lumber and other materials, hosing down a driveway and pushing a wheelbarrow.

He is also observed appearing to work at a facility where he hoses out and brushes with a long handled broom, large containers, which he then pushes. He is also seen walking and pushing a double stroller with two children, both on flat surfaces and up an incline. Mr. Nash participates in all of these activities with fluid movements, no visible use of assistive devices, no visible indication of discomfort and without any evidence of limitation with respect to his upper extremities.

Our reviewer further indicated that Mr. Nash is observed engaging in multiple activites of daily living, including walking, sitting, standing, driving, lifting, carrying, pushing and pulling without limitation. Further, he indicated that Mr. Nash's attending physician contended that he was unable to perform his usual job duties due to inability to sit for prolonged periods, however sitting involves minimal hip joint loading relative to the standing, walking, lifting, pushing, pulling and carrying activities in which Mr. Nash is observed to participate in the video surveillance.

Specifically the medical record closest to November 30, 2005, addresses range of motion of forward flexion of the left hip to 45 degrees with zero degrees internal and external rotation and abduction of 10 degrees. He indicated that there was no significant tenderness to palpation about the hip. The surveillance showed Mr. Nash sitting and driving in several instances and sitting involves less weight bearing of the hip joints than does the other activities in which Nr. Nash is seen to participate over the course of several hours to include standing, walking, lifting, pushing, pulling and carrying.

The results of his review indicated that there was no medical provided that documented any significant physical or cognitive limitations that would preclude working activities. In conclusion the observation of Mr. Nash's observed in engaging in multiple activities of daily living, the limitations and/or restrictions are not supported. Our Peer Reviewer further opined that although unusual, it is possible to sit with the hip flexed at not more than approximate 45 degrees.

After reviewing all of the available information we determined that there was no new or additional information to consider that would refute the previous decision already made on client's your file. Further the information received did not add any further explanation of your client's functionality as of November 30, 2005.

The above Policy provides that benefits are paid if your client was prevented by Disability from performing the duties of his occupation. However, the weight of the medical evidence in your client's claim file supports his ability to perform his own work activities, as the medical information does not support any disability that would that would show that he was not capable of performing his occupation as of November 30, 2005. Accordingly, no benefits are payable under the Policy after November 30, 2005.

Please note that you have a right to bring legal action for benefits under ERISA section 502(a). You and your client's plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local United States Department of Labor Office and your State Insurance Regulatory Agency.

As we have not received any additional information that supports your claim for disability, we are reaffirming our previous denials of your client's claim. Consequently, we will consider you to have exhausted all administrative remedies with our office; therefore, there are no further rights of appeal to our office.

Please review your plan booklet, certificate or coverage information available from your employer to determine if you are eligible for additional benefits.

Section 2695.7 (b) (3) of the Regulations of the California Insurance Department requires that our company advise you that if you wish to take this matter up with the California Department of Insurance, you may contact the California Insurance Department. Their address is California Department of Insurance, Consumer Services Division, 11th Floor, 300 S. Spring Street, Los Angeles, CA 90013, (213) 897-5961, or (800) 927-HELP (4357).

Nothing contained in this letter should be construed as a waiver of any rights or defenses under the policy. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein.

Sincerely,

Karen I. Nichols
Appeals Claim Manager

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STE 1000, LB179
DALLAS TX 75243

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SUSAN L HORNER
ATTORNEY AT LAW
501 WEST BROADWAY STE 700
SAN DIEGO CA 92101-3563

EXHIBIT H -8

EXHIBIT
I

EXHIBIT I

EXHIBIT I

August 29, 2007

Karen I. Nichols
Appeals Claim Manager
CIGNA Disability Management Solutions
12225 Greenville Ave
Ste. 1000 LB 179
Dallas , TX 75243-9384

I am in receipt of your letter dated **July 18, 2007** reaffirming your termination of my disability benefits that LINA had paid for 2 years and 2 months under group policy SLK 30024, prior to the termination. In your letter, you state:

> "Our Peer Reviewer attempted to discuss Mr. Nash's case with Behrooz Tohidi , MD on July 11, 2007 and July 12, 2007. He was unavailable and messages were left with Dr. Tohidi, however, he did not receive a return call."

I contacted Dr. Tohidi's office regarding the two alleged phone messages. His office manager advised me that only one message had been left for Dr. Tohidi, not two. It was left on July 11, 2007, one week prior to the date of your denial letter. Dr. Tohidi's staff advised me that they did not receive any written request by fax or mail and no message either on the voice message or in writing specifying what particular area or subject about me that the "peer reviewer" wanted to discuss. Nor, according to Dr. Tohidi's office personnel, was there any later call made to Dr. Tohidi's office to ask what time or day he could be available, or whether he was even in town that week, and if not, when he was expected to return to the office.

Dr. Tohidi's staff advised me that he was out of the office on the following days: July 9, July 10, July 11, and July 12. His staff also advised me that following his return on Friday July 13, he had an exceptionally busy office and surgery schedule to make up for the time away from the office. His office was closed Saturday and Sunday, July 14-15.

At no time since the date LINA received my final appeal on January 9, 2007, did any employee or agent of LINA ever communicate to me or to my counsel that they would need additional information from Dr. Tohidi or would like to set up a telephone conference call with Dr. Tohidi if possible. This is particularly concerning since Miller Monson had to go through the California Department of Insurance, after LINA's refusal in February 2007 to review the appeal followed by several months of total silence by LINA our numerous letters, just to convince LINA to review my second appeal *that LINA invited me to submit*. My counsel spoke with Mr. Gary Person a couple of times, and by letter, after LINA determined it would review the appeal. At no time did Mr. Person ever contact my attorney to tell her that LINA was allegedly interested in obtaining some additional information from Dr. Tohidi. Nor was there any indication from Mr. Person to my counsel on or after July 26, 2007 (when my attorney faxed and mailed to Mr. Person a copy of Dr. Helgager's most recent medical information) or July 2, 2007 (when my prescription refill records were faxed to Mr. Person) that some type of additional information from Dr. Tohidi would be of interest to LINA. You may notice that I am unable to even make reference to what particular information that might have been, because it was never communicated.

I am very concerned that neither you or your "peer reviewer" notified me or my attorneys that you were trying to reach Dr. Tohidi so that I might assist you in reaching him and getting him your message or if only to ascertain whether he was in or out of the office and when his schedule might permit a response.

Finally, neither you or your "peer reviewer" ever sent to me, my attorneys, or Dr. Tohidi any written questions or description of what information you wanted from him. Dr. Tohidi's letters expressly state his need for and office procedure requiring written questions and answers for proper documentation to his patient chart and to guard against mistaken understandings, miscommunications or misconstruction of information asked or given over the phone. Specifically, the letters Dr. Tohidi submitted addressing my disability offered that he would be willing to answer further questions, but requested that these be put in writing, to avoid confusion about what exactly was being asked and what precisely his answers were. Both you and your "peer reviewer" ignored and tried to circumvent his wishes in trying to make a cold call.

No one at LINA or on its behalf submitted any additional written questions or requests for explanation, or made any arrangements since January 9, 2007 for the submission of questions to Dr. Tohidi. Had they, LINA would have necessarily needed to provide this busy orthopedic surgeon with a reasonable time-period by which he could respond. LINA should have allowed him at least a month as it does for any of its forms completion. Also, Dr. Tohidi could not have communicated with your "peer reviewer" without a written authorization signed by me for the release of information to a person whom Dr. Tohidi has never heard of. There was no notification faxed to Dr. Tohidi's office indicating that Dr. Tohidi was authorized to share any personal or medical information about me with the "peer reviewer."

I do not consider the above indicative of any genuine interest in obtaining any truly important additional information, whatever it might be, or indicative of any genuine attempt to engage in meaningful communication about my condition with Dr. Tohidi. The fact that you made no effort to ask for my or my counsel's assistance in getting questions to Dr. Tohidi and answers from him on something, with your formalized final denial letter being dated one week (four business days) after the alleged call to Dr. Tohidi, suggests to me you or your reviewer did not actually have any questions that have not already been answered by Dr. Tohidi in his notes and letters that are already in the claim file, and that a voice message was left simply so that you could CLAIM you wanted some (unidentified) information but were denied access to it. Dr. Tohidi's staff indicated that nothing in the message indicated any urgency, nor did it even indicate any area you needed information about. Given all the information your "peer reviewer" completely ignored or did not review (or was not given to review), it appears to be an empty effort never intended to be followed up on.

Todd Nash

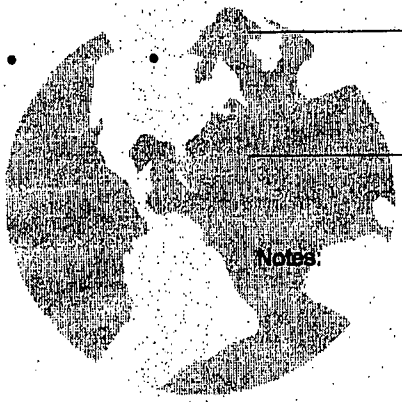
Letter to Karen Nichols, August 29, 2007, page 2 of 2

Todd Nash
2730 Fernglen Road
Carlsbad, CA 92008
760-729-6274
760-518-4823
760-729-6823 (fax)

facsimile transmittal

To:	Karen Nichols	**Fax:**	860-731-3211
From:	Todd Nash	**Date:**	8/30/2007
Re:	Appeal for disability benefits	**Pages:**	3 including cover
CC:			

☐ **Urgent** ☐ **For Review** ☐ **Please Comment** ☐ **Please Reply** ☐ **Please Recycle**



Notes:

TRANSMISSION VERIFICATION REPORT

TIME : 08/30/2007 06:29
NAME : NASH
FAX : 7607296823
TEL : 7607296823
SER.# : BROB4J288016

DATE,TIME	08/30 06:28
FAX NO./NAME	18607313211
DURATION	00:01:09
PAGE(S)	03
RESULT	OK
MODE	STANDARD ECM

EXHIBIT I -4

EXHIBIT J

EXHIBIT J

THOMAS M. MONSON*
MARY J. PESHEL*
TIMOTHY C. POLACEK*
WILLIAM D. HOSHAW*†
ROBERTA D. REPASY*
SUSAN L. HORNER*"
RAY W. RIDLON*
BRADFORD N. DEWAN
DANIELLE C. HUMPHRIES"
JUDY S. BAE

*A PROFESSIONAL LAW CORPORATION
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"ALSO LICENSED IN TEXAS

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FAX NUMBER
(619) 696-6163

REPLY TO FILE:
59812-01-14

September 17, 2007

Via Fax 860-731-3591

Gary Person
Life Insurance Company of North America
CIGNA Group Insurance D212
12225 Greenville Ave., Ste 1000
Dallas, TX 75243-9337

RE: Claimant: Todd Nash
LINA Group Policy #: SLK-030024 (effective 1/1/2000)

Dear Mr. Person:

I am in receipt of your letter dated and mailed on September 14, 2007. Mr. Nash wrote to LINA on August 29, 2007. The letter was addressed to Karen Nichols, who you, as the "manager" of the appeals teams, had indicated to me would be the person reviewing Mr. Nash's voluntary appeal. (That, I reasonably presumed, would be the entirety of it, not just a few documents.) During that review process, neither Mr. Nash or I were ever contacted by Ms. Nichols, or anyone besides yourself. And as for the couple of calls from you, those were after our contacts with the California Department of Insurance, wherein you apologized and indicated that LINA would in fact review the voluntary appeal it invited, also apologizing for LINA's complete nonresponsiveness to a number of our letters to Ms. Bharadwaj. You indicated that LINA would determine if it needed any additional information and contact us if it needed any assistance us. We heard nothing more from LINA. Apparently Ms. Nichols' approach is the same as Ms. Bharadwaj's approach before her; —lack of meaningful (or any) communication with the claimant who is attempting to perfect his claim and get to LINA information it needs. Without such communication, we are left to, as the saying goes, "shoot at the clouds" and try to hit a target —if there even is one— somewhere behind them.

Mr. Nash's August 29 letter articulated concerns he had about the alleged two efforts to make a cold call to Dr. Tohidi when he was out of town (apparently only one retrievable message), regarding some unidentified information that reviewer suggests he needed from Dr. Tohidi. There was no written follow up. Not once did anyone from or on behalf of LINA including the reviewer or Ms. Nichols, ***or you*** (since you stated to me that ***you*** would be "the contact person") communicate to Mr. Nash *or to me* any interest in speaking with Dr. Tohidi, communicate any specific subject or questions, or even suggest what general area of information he may have needed. For all we know, it may have just been a call asking for a confirmation that he prepared and signed some form or letter that he submitted, or it may have been to ask questions that could have been answered had the reviewer actually been provided with and reviewed the whole appeal. He obviously didn't. LINA has certainly never submitted a written request for any specific questions or inquiries for Dr. Tohidi to respond to, despite my understanding that is what Dr. Tohidi's stated wishes are for.

The complete lack of any inquiry to my office regarding Dr. Tohidi's schedule, availability; the complete lack of submission of any written questions or inquiry; and the timing —the rapid-fire final denial a week later indicates that the message to Dr. Tohidi that the reviewer had called was simply a formality *absent of any true need.* Now, instead of reviewing Mr. Nash's written concerns and communications as an objective disinterested fiduciary would, and engage in meaningful communications at Judge Kozinski instructed over a decade ago, in a true effort to meaningfully communicate with me in return, you foreclose communications outright that might get to the bottom of these concerns, and return Mr. Nash's original letter to me. If you elect not to keep a copy of it, that is your own choice. It is a communication that reflects a genuine effort by this claimant to apprise you of continuing serious concerns with the process employed by LINA, in its own interest, overseen on the last "voluntary appeal" round by yourself. Does LINA have any interest in the deficiencies of its appeal reviewer or of his physician paper reviewer who reviewed a number of pre-selected documents? Obviously not.

Moreover, because I emphatically agree with the concerns stated by Mr. Nash, and the obvious selectivity of the paper reviewer, *whether voluntary or by design*, I again formally submit the original of his letter for your files.

Very truly yours,

MILLER, MONSON, PESHEL, POLACEK & HOSHAW

Susan L. Horner

cc: Todd Nash

August 29, 2007 ORIGINAL – Resubmitted

Karen I. Nichols
Appeals Claim Manager
CIGNA Disability Management Solutions
12225 Greenville Ave
Ste. 1000 LB 179
Dallas, TX 75243-9384

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Todd Nash

Letter to Karen Nichols, August 29, 2007, page 2 of 2

THOMAS M. MONSON*
MARY J. PESHEL*
TIMOTHY C. POLACEK*
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ROBERTA D. REPASY*
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*A PROFESSIONAL LAW CORPORATION
†OF COUNSEL
''ALSO LICENSED IN OREGON
'ALSO LICENSED IN WISCONSIN
And HAWAII

LAW OFFICES

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TELEPHONE: (619) 239-7777

Established in 1959

RALPH GANO MILLER
Retired

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http://www.mmpph.com
WRITER'S DIRECT E-MAIL

FAX NUMBER
(619) 696-6163

REPLY TO FILE:

Number of pages, including cover sheet: 5 Date: September 17, 2007

TO: Gary Person

COMPANY: LINA

FAX NO: (860) 731-3591

FROM: Susan Horner

RE: Todd Nash, Policy No SLK 030024

THESE ARE TRANSMITTED:

- ❑ In accordance with your request
- ❑ For your file
- ❑ For your information
- ❑ Please telephone upon receipt
- ❑ Please review and comment
- ❑Xxx Hard copy to follow

COMMENTS:

CONFIRMATION CONTACT:

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Transmit report

P.1

09/17/2007 17:54
27NE00847
TC:263285

REMOTE STATION	START	TIME	Pages	RESULT	REMARKS
18607313591	09-17 17:50	00:03 04	005/005	OK	

REMARKS TMR:Timer, POL:Poll, TRN:Turn around, 2IN:2in1 Tx, ORG:Original size set, DPG:Book Tx
FME:Frame erase Tx, MIX:Mixed original, CALL:Manual-Com, KRDS:KRDS, FWD:FORWARD
FLP:Flip Side 2, SP:Special Original
FCODE:Fcode, MBX:Confidential, BUL:Bulletin, RLY:Relay, RTX:Re-Tx, PC:PC-FAX
S-OK:Stop communication, Busy:Busy, Cont.:Continue, No ans:No answer
M-full:Memory full, PW-OFF:Power switch OFF, TEL:Rx from TEL

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MARY J. PESHEL*
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WILLIAM D. HOSHAW*†
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SUSAN L. HORNER*"
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*A PROFESSIONAL LAW CORPORATION
'OF COUNSEL
"ALSO LICENSED IN OREGON
'ALSO LICENSED IN WISCONSIN And HAWAII

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MILLER MONSON PESHEL, POLACEK & HOSHAW
A PARTNERSHIP OF PROFESSIONAL LAW CORPORATIONS

501 WEST BROADWAY, SUITE 700
SAN DIEGO, CALIFORNIA 92101-3563
TELEPHONE: (619) 239-7777

Established in 1959

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Retired

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WRITER'S DIRECT E-MAIL

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REPLY TO FILE:

EXHIBIT J - 6

Number of pages, including cover sheet: 5 Date: September 17, 2007

TO: Gary Parson
COMPANY: LINA
FAX NO: (860) 731-3591
FROM: Susan Horner
RE: Todd Nash, Policy No SLK 030024

THESE ARE TRANSMITTED:

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- ☐ For your file
- ☐ For your information
- ☐ Please telephone upon receipt
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W:\LIT\LITM-R\NASH, TODD MUTIGATN\Fax Cover to G Parson 9-17-07.wpd (9/17/07)

JS 44 (Rev. 12/07)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON THE REVERSE OF THE FORM.)

I. (a) PLAINTIFFS

TODD NASH, an individual

DEFENDANTS

LIFE INSURANCE COMPANY OF NORTH AMERICA

FILED

2008 MAY 20 PM 3:05

(b) County of Residence of First Listed Plaintiff SAN DIEGO

(EXCEPT IN U.S. PLAINTIFF CASES)

County of Residence of First Listed Defendant

(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE LAND INVOLVED.

(c) Attorney's (Firm Name, Address, and Telephone Number)

Susan L. Horner 619-239-7777
Miller, Monson, Peshel, Polacek & Hoshaw
501 W. Broadway, STE 700, San Diego, CA 92101

Attorneys (If Known)

BY KNU DEPUTY

'08 CV 0893 WQH RBB

II. BASIS OF JURISDICTION (Place an "X" in One Box Only)

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question (U.S. Government Not a Party)
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity (Indicate Citizenship of Parties in Item III)

III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant) (For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT (Place an "X" in One Box Only)

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excl. Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury

PERSONAL INJURY
- ☐ 362 Personal Injury - Med. Malpractice
- ☐ 365 Personal Injury - Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 444 Welfare
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 440 Other Civil Rights

PRISONER PETITIONS
- ☐ 510 Motions to Vacate Sentence

Habeas Corpus:
- ☐ 530 General
- ☐ 535 Death Penalty
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition

FORFEITURE/PENALTY
- ☐ 610 Agriculture
- ☐ 620 Other Food & Drug
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 630 Liquor Laws
- ☐ 640 R.R. & Truck
- ☐ 650 Airline Regs.
- ☐ 660 Occupational Safety/Health
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Mgmt. Relations
- ☐ 730 Labor/Mgmt.Reporting & Disclosure Act
- ☐ 740 Railway Labor Act
- ☐ 790 Other Labor Litigation
- ☒ 791 Empl. Ret. Inc. Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 463 Habeas Corpus - Alien Detainee
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 810 Selective Service
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 875 Customer Challenge 12 USC 3410
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 892 Economic Stabilization Act
- ☐ 893 Environmental Matters
- ☐ 894 Energy Allocation Act
- ☐ 895 Freedom of Information Act
- ☐ 900Appeal of Fee Determination Under Equal Access to Justice
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN (Place an "X" in One Box Only)

- ☒ 1 Original Proceeding
- ☐ 2 Removed from State Court
- ☐ 3 Remanded from Appellate Court
- ☐ 4 Reinstated or Reopened
- ☐ 5 Transferred from another district (specify)
- ☐ 6 Multidistrict Litigation
- ☐ 7 Appeal to District Judge from Magistrate Judgment

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (**Do not cite jurisdictional statutes unless diversity**):
29 U.S.C. Section 1132(a)(1)(B) and (a)(3) ERISA Section 502

Brief description of cause:

VII. REQUESTED IN COMPLAINT: ☐ CHECK IF THIS IS A CLASS ACTION UNDER F.R.C.P. 23 **DEMAND $**

CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☒ No

VIII. RELATED CASE(S) IF ANY (See instructions): JUDGE DOCKET NUMBER

DATE May 20, 2008 SIGNATURE OF ATTORNEY OF RECORD Susan Horner

FOR OFFICE USE ONLY

RECEIPT # 151145 AMOUNT 350. APPLYING IFP JUDGE MAG. JUDGE

5/20/08 [initials]

cs

UNITED STATES
DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA
SAN DIEGO DIVISION

151145 - SR

May 20, 2008
15:07:07

Civ Fil Non-Pris
USAO #.: 08CV0893 CIV. FIL.
Judge..: WILLIAM Q HAYES
Amount.: $350.00 CK
Check#.: BC#2944

Total-> $350.00

FROM: NASH V. LIFE INS. CO. OF NO. A
CIVIL FILING